# THE AMAP REPORT
# VOLUME 2


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# Introduction

In April 1997 a group of midwifery educators, practitioners and researchers met in Melbourne to share their experience of current issues affecting midwifery in Australia. An increasing level of concern was being raised by these individuals, who identified problems with standards of education, midwifery practice and the limited range of midwifery services available to women. Informally, through various networks there was growing consensus that midwifery education and practice in Australia was falling behind standards elsewhere and that urgent evaluation and assessment was required. At this meeting, a plan was developed that included a decision to pursue funding for a major national study about midwifery and the role of midwives in Australia. At about the same time the organisation known as 'Women's Hospitals Australia' (subsequently to become 'Women's Hospitals Australasia') and the Directors of Midwifery Services approached me with concerns they had about standards of newly graduated midwives. A subsequent meeting with the consumer group known as Maternity Coalition began consumer involvement in the study. The development of a funding proposal by researchers from the fields of midwifery, nursing and sociology followed engaging industry partners in a joint project. Five separate industry partners agreed to commit funds to support research to examine the issues. These partners were 'Women's Hospitals Australia' (subsequently to become 'Women's Hospitals Australasia', the NSW and South Australian Health departments, South East Health, a large area health service in Sydney and ACMI (the Australian College of Midwives). We are very grateful for the support of Industry initially and over the duration of the Project.

The *Australian Midwifery Action Project* (AMAP) subsequently received funding from the Commonwealth government through the Australian Research Council as part of its 'Strategic Partnerships with Industry Research and Training' (SPIRT) program. The project commenced in April 1999 with a goal to identify and investigate barriers to midwifery within the provision of mainstream maternity services. The overall aim of the study was to conduct an analysis of the effects of recent changes in maternity care policies, midwifery regulation and educational systems as well as models of care and practice. The design of the study, made possible through the SPIRT program, offered a mechanism to enable the research training of two midwives, who would simultaneously conduct the study under supervision and receive concomitant post-graduate research training. An investigator on the Project, Nicky Leap from Flinders University, later moved to Sydney and also completed her doctorate also related to the AMAP work.

The research endeavoured to maintain a national focus through the extensive use of Internet technology, networking and structured workshops undertaken in all states and territories over the three years. Chief Investigators contributed from three states and four universities. Industry partners were represented at AMAP meetings on different occasions by members from all states and territories.

The two main aims of the research project were:

- To investigate the service delivery, educational, policy and regulatory environments affecting midwifery in Australia;
- To analyse and facilitate collaboration, planning and communication across these sectors.

I have been privileged to lead the AMAP Team as we investigated the service delivery, educational policy and regulatory environments affecting midwifery in Australia. Our goal has been to provide information to assist industry partners, health departments, health services, universities and regulatory bodies to improve maternity care.

Midwives are the largest single group of health workers in the maternity care system. No comprehensive analysis of Australian midwifery policies was available at the time the research began, nor were the effects of recent changes in midwifery policies, regulation, education and service delivery well understood. Policy and planning is constrained by divisions within and between the professions of midwifery and nursing, and by inadequate communication between stakeholders involved in maternity care. Recent evidence suggests that the industry is having difficulty maintaining high quality services because of shortfalls in the number of midwives, especially in rural and remote areas, and there are concerns by employers over the standard of some graduates (NSW Health 1996). As over 250,000 instances of care are provided by Australian midwives each year (Nasser et al 2001), a national study was urgently needed to investigate constraints on the midwifery contribution to maternity care.

The project investigated maternity service provision, midwifery education, policy and regulation and analysed the barriers to safe and cost effective midwifery care. It also examined the problems of communication and co-ordination across these sectors. An action oriented research process facilitated

the collaboration of Industry Partners, researchers, relevant organisations and the wider community in active collaboration throughout the project. This positioned the work to actively inform and support improvements in midwifery care. Important research participants included health services and agencies who provide maternity care; professional organisations for midwifery, nursing and obstetrics; educators and institutions involved with midwifery education; statutory authorities responsible for the regulation of midwives; and consumer groups. These stakeholders collaborated in the research to generate the outcomes needed to inform: maternity service policy and service provision; the education of midwives; the workforce and the regulation of midwives within the maternity sector.

The research has provided information that will assist the professions, health departments, health services, universities and regulatory bodies to co-ordinate planning and improve their contribution to the quality of maternity care in Australia. The research process is described in full in Volume 1.

Two research midwives, Pat Brodie and Sally Tracy, conducted the research on a full-time basis, along with Nicky Leap as Chief Investigator initially from Flinders University, South Australia and then, UTS, Sydney. The project was managed by Ruth Worgan.

As Chief Investigators, Karen lane and Kerreen Reiger contributed their discrete research and, with Linda Saunders, provided support to the UTS researchers in carrying out the project.

The team was lead from UTS, and I was responsible for project design and oversight. My role was to supervise the student candidature of Pat Brodie (PB), Sally Tracy (ST) and Nicky Leap (NL), to coordinate investigators and to supervise the activities of employed staff and stakeholders involved.

Volume 2 of our report, presented here, contains work conducted under AMAP and endorsed fully by all Industry partners. On behalf of the industry partners, investigators, employed staff and doctoral candidates I commend this Volume prepared from our work to you.

Professor Lesley Barclay

February 2003

# Terms of Reference

The contract between UTS and the Industry partners (Schedule 2) stated that a national research project entitled 'The improvement of midwifery care', would 'provide information that [would] assist Industry Partners, health departments, health services, universities and regulatory bodies to co-ordinate planning and improve the implementation of maternity care.

The two main aims of the research project were:

- To investigate the service delivery, educational, policy and regulatory environments affecting midwifery in Australia;
- To analyse and facilitate collaboration, planning and communication across these sectors.

Two senior research officers (postgraduate research students) would undertake candidature in a doctorate at the University of Technology, Sydney, under the supervision of the appointed team leader, Professor Lesley Barclay, and produce research theses around Strand I and 2 from the project data, [to] inform the final report.

# Explanatory Note

Volume 2 of the AMAP Report contains material that was unanimously endorsed by Industry Partners. Additional research papers and reports that are not included here in Volume 2, can be found in the Professional Doctorates of Sally Tracy, Pat Brodie and Nicky Leap, and will be published as a book of readings by the Centre for Family Health and Midwifery at a later date. An Appendix to Volume 2 refers the reader to papers that have been published, but were either not supported unanimously by Industry Partners or produced subsequent to the grant completion. They have therefore not been included in Volume 2.

Related work was conducted by investigators and doctoral students, in and outside the hours of paid employment and responsibility to AMAP. This additional work enhanced the productivity of AMAP. Investigators can be contacted for details of this work that is in preparation for publication.

**ADDRESSING THE BARRIERS TO MIDWIFERY - AUSTRALIAN MIDWIVES SPEAKING OUT**

**Brodie P.** (2002) Addressing the Barriers to Midwifery: Australian Midwives Speaking Out. *Australian Journal of Midwifery*.15 (3): 5-14

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**ABSTRACT**

This research gives a voice to midwives in identifying the barriers and current problems in the organisation of maternity care in Australia. Using a critical feminist research approach, data was collected from a cross section of midwives nationally. Through standard qualitative research methods, themes were identified that enabled analysis of significant issues affecting the current status of midwifery.

The system of maternity care was identified as being dominated by medicine, not evidence based and restricting of women's choices, with midwifery autonomy not recognised or supported. The invisibility of midwifery within the community was identified as a significant barrier which, in conjunction with the occupational imperialism of obstetrics, ensures ongoing strategic control of maternity services and a denial of the rights of consumers to access midwifery care.

## INTRODUCTION

This study as part of a larger project[1] explores and reports the views of midwives from across Australia in identifying the barriers to midwifery within mainstream maternity service provision.

## CONTEXT AND LITERATURE REVIEW

In Australia, there are approximately 250,000 live births annually (Nassar and Sullivan, 2001). The majority of these births take place in hospitals staffed by approximately 13,800 registered midwives and nurses working in midwifery (AIHW, 2002), with medical care available either 'on call' or 'on site'. High standards of maternity care are based on the assumption that there is, and will be, the availability of qualified midwives for all women during labour, birth and the postnatal period. Whilst there are clearly areas requiring significant improvement, particularly with regard to Indigenous perinatal outcomes, childbirth in Australia is considered relatively safe compared to international standards, with a fetal death rate of 6.7 per 1,000 live births (Nassar and Sullivan, 2001).

Research investigating systems of maternity care suggests that there are positive benefits for women and health systems associated with the increased utilisation of midwives' skills (Waldenström and Nilsson, 1993) Rowley et al. 1995; (Homer et al. 2000; MacVicar et al. 1993; Flint et al. 1989). An Australian trial of 1089 women (Homer et al. 2001a) and a Canadian trial of 200 women (Harvey et al. 1996) both demonstrated that continuity of midwifery care can lead to a significant reduction in caesarean section rates. In Britain, supported by increasing evidence of their benefits (Rooks et al. 1989; Campbell and Macfarlane, 1994; Hodnett, 2001), there is a growing movement towards the expansion of midwifery led, free standing birth centres (Walsh, 2000). Continuity of midwifery care has also been associated with reduced costs to the health system in three Australian studies (Rowley et al. 1995; Kenny et al. 1994; Homer et al. 2001b).

The potential to reorganise and improve the efficiency of Australian maternity services through an increase in the utilisation and recognition of the midwife's role is demonstrated through research, policy and planning documentation (NHMRC, 1996; NHMRC, 1998). However, actual evidence of widespread change and reorganisation in service provision is much less evident. The AMAP study sought to provide evidence on which to base strategic planning and to bring about improvements in midwives' contribution to maternity care through facilitating and supporting institutional and systemic reform. Within this context the views of midwives were sought to answer two research questions:

1. What are the barriers to the provision of safe, efficient and economic midwifery care within maternity services in Australia?
2. What are the strategies to overcome these barriers?

[1] The *Australian Midwifery Action Project* (AMAP) was funded by the Australian Commonwealth Government through the Australian Research Council as part of the then 'Strategic Partnerships with Industry Research and Training' (SPIRT) program. A three-year project, AMAP was set up in April 1999 to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia. This included workforce, regulation, education, and practice and service delivery issues across the country.

## METHOD

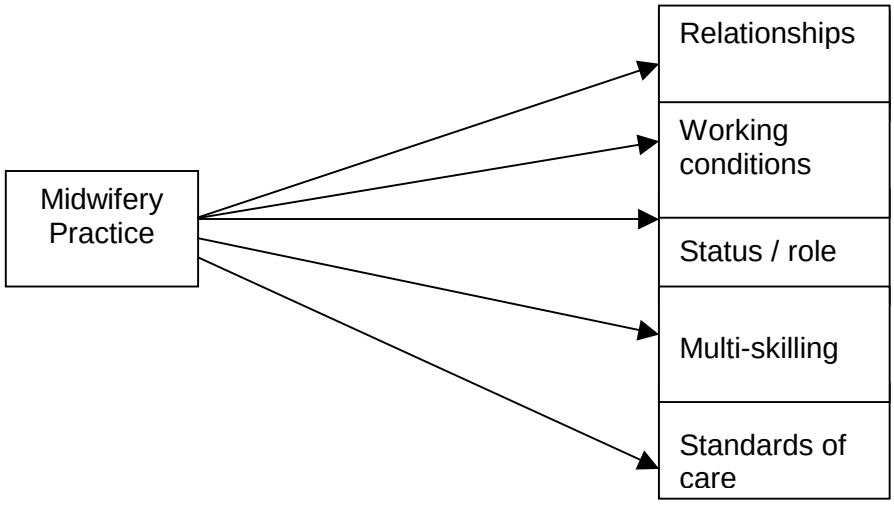
### Sample and data collection

Multiple data collection methods were used over a two-year period. Interactive forums with groups of midwives participating in 28 separate professional conferences and seminars as well as the use of 'graffiti[2] boards, anonymous surveys or 'graffiti' sheets (Appendix A) placed in professional journals (Table 1) and on a website, were all utilised. Five hundred and sixty three responses were received, with three hundred and ninety six respondents (73.3%) stating that they were registered midwives in current practice. Geographic spread of respondents was extensive with sixty-eight responses (28.8%) from participants with postcodes identified as coming from either remote or rural regions.

### Data analysis

Using the NUD.IST software program, data was analysed for thematic content (Strauss A & Corbin J, 1990) and ascribed labels identified as 'nodes'. Attaching nodes to the data enabled the researcher to conceptualise and arrange observations, words and responses into themes that allowed for further analysis and interpretation (Strauss A & Corbin J, 1990). As an example, Figure 1 demonstrates the 'parent' node for the theme 'midwifery practice' and the five 'child' nodes that relate to it. Thus the 'parent' node 'midwifery practice' represents the linkage of a number of themes that arose in the data from the sub group of 'child' nodes.

**Figure 1: Coding of the relationship of the 'midwifery practice' 'parent' node to related 'child' nodes**

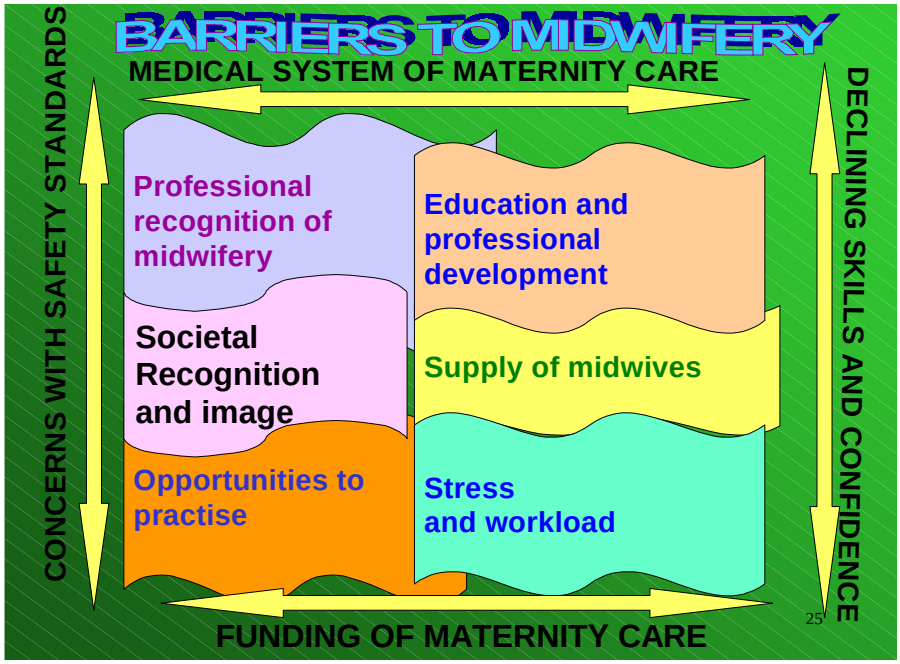



[2] The term 'graffiti' was used to describe the process of obtaining the explicit views of the midwife participants. This method has been explored and described in detail by Sally Tracy (2002 in press).

**RESULTS**

A clear picture of the challenges facing Australian midwifery practice has emerged from the midwives' data. Respondents described their role and practice as being constrained by several factors. These factors have been grouped around several sub-sets of themes related to service provision and the practice domain of midwives. These were then assembled as a map to visually demonstrate the complexity of barriers to practice as well as the broader service provision environment that participants described (Figure 2).

**Figure 2.**
**Complexity of barriers to Australian midwifery**



Throughout the reporting of the results, key issues and strategies are illustrated through the use of quotes. These are then incorporated and reflected in the analysis and discussion.

## KEY THEMES EMERGING FROM THE ANALYSIS

### Professional recognition

Reports of lack of professional recognition of midwifery and the role of the midwife came equally strongly from midwives in urban and rural settings. The philosophy of care, whether the workplace culture was medically focussed or woman-centred,[3] played a part. Models of medically dominated practice were not the exclusive domain of medical practitioners, with reports that some midwives and unit managers also supported a 'medical' approach to care. For some, this was perceived to occur because of a lack of recognition of the benefits of midwifery and the high level of nursing and medical dominance of midwifery practice that restricted midwives' desire to fulfil their role

> "We need to overcome the medical ownership of maternity care and this will not only involve focusing on doctors, but also on challenging the practice of many current midwives who rely on the security blanket of 'medicalisation' " (AL 2)

> "There are times when it feels like two teams working from different paths – women centred vs medical controlled care - all aiming for the women to have a safe birth but not really believing in each other's methods or supporting each other's practices." (DA 1)

In some areas, midwives described an urgent need for role models or more skilled midwifery leaders. This need was exacerbated by an overt focus on 'nursing' in matters of professional education, management and organisational leadership.

> "It's a medical model of care which is perpetuated by the nursing profession as well. We need stronger recognition of midwifery as a separate profession from nursing. (AS5)

A perceived resistance to change, such as reluctance to develop midwifery models of care and evidence based practice, was reported. Whilst there were several notable exceptions, resistance to both change and the embracing of midwifery models of care was a recurrent theme that emerged from the analysis.

> "Many of the midwives here have never professionally updated themselves and they are essentially barriers to women's choices." (AD 2)

[3] In midwifery, 'woman-centred' is a concept that implies the following: Midwifery focuses on a woman's individual, unique needs, expectations and aspirations, within the recognition of her particular social milieu, rather than the needs of the institutions or the professions involved. Implicit is the notion that 'woman-centred' encompasses the needs of the baby, and the woman's family, her significant others and community, as identified and negotiated by the woman herself. Midwifery recognises the woman's right to self-determination in terms of choice, control and continuity of care from a known or known caregivers. Midwifery follows the woman across the interface between institutions and the community, through all phases of pregnancy, birth and the postnatal period. It therefore involves collaboration with other health professionals when necessary. Midwifery is 'holistic' in terns of addressing the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations (Australian College of Midwives Inc., 2002)

**Opportunities to practise**

Opportunities to practise across the spectrum of maternity care varied according to how services were organised and the prevailing philosophy of care. For example a 'medical' model of care, where general practitioner obstetricians provided all antenatal care and had responsibility for intra-partum care, resulted in midwives not having access to antenatal practice as well as experiencing a reduction in their autonomy in decision making. This had the effect of midwives feeling that they were losing their skills and confidence in providing antenatal and intra-partum care. Many reported a narrowing scope of practice associated with lack of opportunities to provide basic midwifery care. Midwives in large urban centres reported systems that segregated care into antenatal, labour or postnatal care with the midwife's role limited to one area.

> "We don't get an opportunity to work in all spheres of midwifery for which we are qualified. There is no ability to practice in the community due to lack of government financial support and the medical dominance of all aspects of maternity care. There is a real lack of autonomy in midwifery practice". (ME 21)

**Societal recognition and image**

The lack of recognition and status of midwifery within society was identified as a barrier to midwifery's ability to make a significant contribution to improving health outcomes. Participants identified the need for greater understanding about midwifery within the community.

> "Encouraging women to get together and share their experiences of birthing and mothering is urgently needed. Working with young people in schools (adolescents) to explore their views and issues around birthing and families would help understanding and improve things for the future". (AD 11)

Strategies were frequently suggested that addressed the lack of visibility of midwifery. These included promoting public awareness and educating local doctors about the role and functions of midwives, and a call for midwifery's professional organisation to show leadership and advocate for increased recognition of midwifery within the community.

> "There is an absence of any public education about midwives and keeping birth normal - this is now becoming an urgent public health issue." (SYD 22)

> "We lack good quality collaboration between medical officers and midwives at the highest level. The ACMI needs to show the way!" (WB 30)

**Supply of midwives**

Midwives reported increasing workloads and diminished staff allocations and resources. This was most notable when caring for women in established labour where high ratios of women to midwives and inadequate numbers of qualified staff were common. Some midwives reported inappropriate skill mix in areas where nurses without midwifery qualifications are working in midwifery without

'supervision'. In some cases, most notably in rural units, there were reports of a staff skill mix based on several enrolled nurses, one or two registered nurses and only one or two midwives. The issue of inadequate workforce numbers coupled with the falling competence and confidence of midwives was linked to concerns about the quality and safety of services.

> "There is no longer a large pool of midwives to employ and train up to an adequate level of knowledge and competence. I am a senior CNS midwife who works night shift and staff shortages frequently place my clients at risk. Even at private hospitals patients are unhappy with level of care due to understaffing. Service comes at a cost - more staff please! (B 59)

**Stress and workload**

In identifying their concerns about the quality and outcomes of care within maternity units, some midwives detailed the consequences of working in stressful working environments. Lack of time for providing 'non-medical or non-urgent care', much of which is central to midwifery care and beneficial outcomes, was reported. This was said to lead to stress and frustration, which, for some, compounded feelings of diminishing competence and confidence. In units where workload and stress levels were continually high, morale was reported as low which in turn became an additional barrier to midwives' capacity to provide effective services..

> "Management have completely unrealistic expectations regarding financial goals versus delivery of safe care. Ratio of midwife to patient is 1:8 and at night its 1:14 or 1:20. We cannot do the tasks required even for safe practice – women are suffering and at times are at risk" (SYD 10)

**The 'system' of maternity care**

A recurrent theme running through much of the data was the 'organisation of maternity care'. The features of this 'organisation' were seen as being reinforced by a public perception and government policy that prioritises medical responsibility for maternity care. Participants identified these two features as the main 'structural' barriers to women's access to midwifery care in both the private and public health systems. The need to increase women's ability to access midwives, most particularly in the antenatal period, were seen as two of the main strategies to improve current service provision.

> "Financial structures restrict independent midwives and limit women's choices of care. In our region, women in low socio-economic situations are often having limited or even no antenatal care because their only option for care is to pay a fee for medical care. There is no midwives' clinic, there are no GPs performing obstetric care and no funding goes to midwifery models. The obstetricians have a frightening balance and use of power". (AD1)

According to participants, midwifery models in the current Australian health system are viewed as difficult to implement unless there is strong support from medical practitioners along with effective leadership and support from midwifery leaders and departmental managers. In spite of considerable evidence attesting to the potential benefits, many midwives reported tier observations

of resistance to change and innovation, especially when those changes involved increased autonomy and responsibility for midwives.

> "It appears to me that the heads of most hospitals i.e. Executive Committee, Directors of Nursing and the obstetricians of this country are following the American 'medical model' of high-tech care for pregnant and birthing women and ignoring proven successful women/community centred models which are based on good evidence and shown to be working elsewhere. (PO 2)

Within a milieu of medicalised maternity care, many midwives report feeling unable to practise midwifery, with an associated loss of confidence leading them into a defensive mode of practice.

> "The medicalisation of childbirth and the reality/perception that consumers are becoming more litigious are the big blockers for midwifery. I now lack the confidence which I used to have and I know this leads me to do more (often unnecessary) interventions which can contribute to increased morbidity. I just cant fight it anymore" (NLR 17)

The lack of midwifery models in rural and remote areas was especially problematic for midwives in these settings. Coupled with lower birth rates and frequent requirements to also work as nurses, rural and remote midwives were particularly at risk of losing skills and confidence in the provision of safe and effective care.

> " ... it is difficult for the midwife on duty to give one-on-one care to a labouring woman and maintain her skills if she is also in charge of the other patients in the hospital and the outpatient department." (AL1)

Of particular concern is the plight of remote maternity service providers.

> "ACHS [Australian Council on Health Care Standards] has set standards which remote rural communities can't achieve - therefore we lose our maternity services. Clients have to travel to other (big) centres - quite long distances - for confinement. Separated from family etc. Often returning to remote community early with no follow-up in community. Hence poor breastfeeding rate etc." (NSR 10)

**Midwifery Education**

The two research questions did not specifically request information about education from participants. In spite of this, many responses referred to education issues when identifying barriers to midwifery service provision. Of note, were concerns expressed about the quality of new midwifery graduates who lacked the capability to 'hit the ground running'. The capacity to begin practising competently from day one was seen as an essential attribute for new graduates arriving in what were usually described as busy units, with high workloads and few resources to support, teach or mentor new staff.

> "Poor preparation i.e. newly 'qualified' midwives with minimal practical skills. Please extend length of the courses to that which will produce good safe practitioners". (ME 9)

> "As a junior midwife working in a large teaching hospital, the lack of midwifery educator in the labour ward has posed many challenges and problems for newly graduated midwives." (SYD 67)

The major education issues identified by participants centred on the quality of clinical placements, level of supervision of midwifery students and the lack of exposure to a full range of midwifery practice skills. In some states, students do not participate in antenatal clinics involving midwives and midwifery students and do not have exposure to practice models other than medicalised maternity care.

Many registered midwives said they were unable to access ongoing education and saw this as a major barrier to feeling confident in providing safe, efficient and appropriate care. Respondents in rural areas also reported difficulty in accessing relevant educational updates and reported being 'fearful' and 'uncertain' and less likely to be able to challenge poor practice and out of date policy.

> "Lack of education for midwives who re-enter the workforce after extended breaks is a big problem. Midwives who have lost the confidence to work in birth suite / labour ward need proper support and education to regain those skills. There are major professional and workforce issues". (CA 7)

Rural and remote area midwives had particular concerns related to geographical isolation and lack of opportunity to access education because of limited access to funded support.

> "Provide funding for midwives to maintain their skills by having exchange agreements with metro hospitals for rural midwives to be seconded to update their skills in the common aspects of midwifery, including emergencies". (NSR 16).

**DISCUSSION**

This study was designed to give a voice to a cross section of midwives who are currently practising and thus arguably, are in the best position to identify, through experience, the existing barriers to their role and practice. The participants have highlighted the need for review and a reorganisation of midwifery services in mainstream maternity care. Their responses indicate that Australian midwifery is in crisis. This relates to significant workforce shortages, problems of quality of educational preparation, serious concerns with workload, quality of care and safety, and access to ongoing professional development and support. A picture of a midwifery workforce that is under-resourced, depleted in numbers and skill mix and that is under-recognised as a profession has emerged, which has serious implications for service providers, policy makers and the profession itself. These findings further substantiate concerns raised in recent Australian research regarding both the midwifery workforce (Tracy et al. 2000) and the obstetric workforce (AMWAC, 1998) and standards of midwifery education (Leap and Barclay, 2002) and regulation (Brodie and Barclay, 2001).

Considerable research has examined the experiences of midwives involved in 'midwifery led' models of care (Green et al. 1998; Sandall, 1997; Brodie, 1996; Stevens and McCourt, 2002) or in the reorganisation of traditional services (Sikorski et al. 1995). In the United Kingdom (UK), several authors have explored the potential impact of health service policy change and reform on the future role of the midwife (Bennett et al. 2001; Lavender et al. 2001). Whilst welcoming changes that may improve services to women, midwives in one study highlighted concerns about additional workload and the need for ongoing education to enable them to adapt to the proposed new roles (Pope and et al, 1996). Australian research has revealed wide-ranging and differing views of midwives' self perceptions of their professional identity and views of childbirth (Lane, 2002).

A recently released report commissioned to determine why midwives leave the profession in the UK has highlighted increasing stress levels, insufficient staffing, and lack of effective leadership and support as some of the key issues contributing to attrition rates (Ball et al. 2002). These UK findings are reinforced by the voices of their counterparts in Australia.

Midwives in this study demonstrated a clear understanding of the challenges facing service planners and managers with surprisingly few participants recommending financial incentives for midwives as a solution. In particular, midwives expressed concerns with the current organisation and funding arrangements for maternity care which were seen to benefit medical practitioners, and restrict women's choices. Many identified direct funding of midwifery care within a broader public health approach as a key strategy to address these structural barriers.

Within this context, midwifery autonomy is not recognised or supported and this could be contributing to lack of job satisfaction and increasing attrition from the midwifery workforce as found in Britain (Stafford, 2001; Ball et al. 2002). Coupled with an 'organisational cultural norm' of high-tech medical management (Mason, 2001) and escalating levels of medical intervention (Roberts et al. 1999), the role of the midwife in Australia was seen by participants as being dominated by medicine (Willis, 1983) and controlled by nursing (Barclay, 1985; Summers, 1998). This is further exacerbated by a perception that the medical profession controls management decisions and resources. Such 'occupational imperialism' (Larkin, 1983) further subordinates midwifery by ensuring strategic control of maternity services and denying the rights of consumers to access midwifery care.

Within this organisational culture, many midwives are unable to fulfil the role for which they were educated and are losing their skills and confidence. Inappropriate use of enrolled and registered nurses and shortages of qualified midwives has a cumulative effect on the capacity of midwives to contribute effectively and safely to maternity service provision. Many respondents reported lack of support and recognition from nursing managers and this was linked to a perception that midwifery professional identity and image was confused with nursing. This is particularly problematic when allocation of staff is based on the 'acuity' and 'medical' needs of patients. In maternity services, women are usually healthy and their needs may be 'invisible' when compared to acute care patients who will always have priority in any distribution of resources to enable safe care. Midwives

in this study highlighted greater recognition of midwifery work as a key strategy to midwifery being able to contribute effectively to maternity services.

Many respondents identified the lack of recognition of midwifery within the community as a significant barrier. Currently in Australia, midwifery remains 'invisible' in a legal sense throughout all State and Territory Nurses Acts, (Brodie and Barclay, 2001; Bogossian, 1998; Barclay, 1985). A published review of the Nurses Act in one state recnetly has led to recommendations for new legislation that will allow the public to clearly identify the profession of midwifery (NSW Health Department, 2001).

Until midwives are distinguishable and accountable through regulation, the public has no way, from a legal perspective, to properly identify midwives or to determine what should be expected of their practice (Brodie and Barclay, 2001). This should be of concern because a number of maternity health care leaders and policy makers are currently seeking to maximise midwives' contributions through the development of models of care that increase midwives' role in service provision (NHMRC, 1998; NHMRC, 1996; NSW Health Department, 1996; NSW Health Department, 2000; Health Department of Western Australia, 2001; Pinch et al. 2001). At the same time, governments and health services are increasing the emphasis on consumers' participation in health service planning, delivery, monitoring and evaluation (Commonwealth of Australia, 2001). As proposed by participants in this study, a more knowledgeable and informed consumer will narrow the gap in knowledge that exists between the community and health professionals. This may lead to demand for greater choice and equity of access to maternity services, including primary care from midwives. There is now evidence of this demand being made by consumers that may herald an improvement in the public recognition of and access to services offered by midwives in Australia (Maternity Coalition and et al, 2002). As was found in South Australian research, when women have the chance to experience midwifery care they are much more likely to chose it in subsequent pregnancies (Zadoroznyj, 2000).

The need for a clear image of what midwifery 'is', including recognition by communities, governments and funding bodies, is a key to increasing midwives' professional status, confidence and self worth. From this analysis, the midwife's identity and role appears stranded between its subsumed position within nursing, and an expectation and a professional desire to develop autonomous practice. Existing organisational structures as well as systems of education, regulation and service provision are reinforcing and sustaining both the subordination (Willis, 1983) and the invisibility of midwifery.

**CONCLUSION**

This study has revealed significant concerns identified by midwives that constitute barriers to midwifery being able to fulfill a legitimate role in maternity service provision in Australia. Within a context of widespread health policy change designed to address the costs and morbidity consequences of current medically dominated maternity care and the introduction of some flexible

models of maternity care, midwifery's current capacity to continue to contribute is questioned. Currently, within a medically dominated health system that subordinates midwifery within nursing, the role of the midwife in Australian health services and the broader community, remains largely invisible, unrecognised and under-utilised. Within this context, lack of midwifery autonomy may be contributing to lack of job satisfaction and increasing attrition from the midwifery workforce.

If midwifery is a key to improving outcomes for women, as is evident from considerable high quality research, the need to strengthen the organisation and systems of midwifery in Australia is clear. This must include joining with women and consumer organisations in advocating for midwifery care. Midwifery is potentially central to sound public health planning (Kaufmann, 2002) and requires recognition, authority and support if it is to make an effective contribution to the provision of safe, efficient and economic maternity services in Australia at any stage in the future.

Midwives themselves have demonstrated an understanding of the wider issues and identified strategies for improvement. If these are to be realised, well-informed and skilful leadership will be required. Leadership that engages with consumers and draws on evidence and international experience to bring about changes in the organisation of maternity services, including the funding of midwifery care and the reform of midwifery education and regulation, will go a long way towards bringing the barriers down – for women and for midwives.

*Author's note*

*As this study was conducted during 1999 and 2000 the withdrawal of indemnity insurance for midwives was not recognised by these participants as a major 'barrier' to midwifery. It is the view of the author that lack of professional indemnity insurance has recently become a further barrier to midwifery in Australia.*

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**APPENDIX**

Appendix A Sample ‘graffiti sheet’ survey is available on request from the author.

**TABLES**

**Table 1: Journals and publications that were utilised for the distribution of the ‘graffiti sheet’.**

| |
|---|
| Australian Nursing Journal |
| Journal of the Australian College of Midwives |
| The Lamp – Newsletter of the NSW Nurses Association |
| The Queensland Nurses Journal |

# Contemporary issues in the workforce and education of Australian midwives

SALLY TRACY, LESLEY BARCLAY, AND PAT BRODIE

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## Abstract

*This paper, which is based on the preliminary findings of the Australian Midwifery Action Project (AMAP), outlines the issues around the midwifery labour force and education in Australia. One of the most alarming features is the lack of comprehensive data on midwives. Where data is available it demonstrates the shortage of midwives and the lack of consistency in educational programs for midwives within states and nationally. It is difficult to form a national picture with published sources of data because there are differences in definition and a lack of relevant information. Strategies for educational reform are discussed in relation to improving the supply and preparation of midwives.*

## Australian population data

The practice of midwifery is integral to the care of women in childbirth. In Australia during 1998 there were 249,600 live births, the majority of which occurred within the hospital setting (ABS 1999). The crude birth rate has declined from 21.7 per 1,000 people in 1971 to 13.9 per 1,000 in 1996 (AIHW 1998). Since 1984 the infant mortality rate has almost halved from 9.24 deaths per 1,000 live births to 5.86 in 1994 for non-Indigenous mothers. However it remains nearly double that rate for Indigenous women (AIHW 1998).

Over the decade 1984-1994 the overall fertility rate remained stable at 2.1. The latest figures show this has dropped, however, to 1.76 for non-Indigenous women in 1998 (a figure slightly higher than some European countries), and remains at 2.2 for Indigenous women (AIHW 1998, ABS 1999). The population projections of the Australian Bureau of Statistics show that the fertility rate could fall to 1.75 in the years 2005-6, but should remain constant at that rate (ABS 1999).

Despite fertility being below replacement level, Australia's population is projected to grow through natural increase until at least 2041 because of the large numbers of women of childbearing age. This is an echo effect of the post war 'baby boom' caused through the grandchildren of the large number of people born in the 1950's and 60's having their children (ABS, 1996). Population projections demonstrate a continuing need for maternity care that is dependent on various levels of skill and expertise. Australia's high standards of maternity care assume the presence of qualified midwives who offer safety and support for women in childbirth and the puerperium in collaboration with medical colleagues, and increasingly as alternative providers (AMWAC 1998). The shortage of registered midwives will inevitably impact on the quality of care provided in maternity services.

## An ageing midwifery labour force

The Australian Institute of Health and Welfare report, "Nursing Labour Force, 1993 and 1994" showed that the proportion of nurses aged less than 25 years had declined from 33.3% in 1981 to 6.0% in 1994 (AIHW

1995). This change in the structure of the workforce was largely due to 'nurse training moving from hospitals to universities and to increases in retention and labour force participation resulting from improved part-time employment opportunities' (Harding 1997p129). The latest figures show that the trend has persisted, and the average age of all employed nurses was 39.9 years (AIHW 1999).

Where data is available it shows that the midwifery workforce reflects this profile even more strongly. For example a recently published study by Watson et al found that nurses were five times more likely to be in their twenties than midwives - 26% compared to 5% (Watson et al 1999). The study of 240 practising midwives in Victoria found that at least half of those in full time employment were over 40 years (Watson et al 1999).

## The midwifery labour force data that exists - AMWAC and other sources

The availability of data on the midwifery labour force is one of the most pressing issues. The capacity to draw meaningful conclusions is compromised because of the use of non-standardised terminology and the incompatibility of databases and data domains (NSW Health 2000). The Australian Medical Workforce Advisory Committee (AMWAC) recently published its study of the supply and requirements of the obstetric and gynaecology medical workforce in Australia (AMWAC 1998). It attempted, but had difficulty in providing baseline data on midwives for this study. All States and Territories who responded indicated that there was an under supply of midwives. However, Victoria, South Australia and Queensland were unable to respond at all (AMWAC 1998). As in other nursing workforce publications, the AMWAC study data does not differentiate between enrolled and registered nurses working in midwifery and obstetrics in Australia. In Australia, a midwife is a specialist in the field of midwifery, who has gained a general nursing qualification (about three years) and then post graduate qualifications to enable her to register as a certified midwife (one to three years - depending on what course she takes.) The data specific to the profile of midwives showed that in 1995, 99.0% of the midwifery workforce were female, 25% of midwives were aged between 35 - 39 years, 65.5% of midwives are aged over 35 years.

Data which was not specific to midwives showed that in 1995, 74.1% of nurses employed as clinicians in midwifery and obstetrics were based in capital cities, 23.9% were located in rural areas and 1.9% were in remote areas.

A more complete picture of the midwifery work force was derived from all available sources of published data, including the AMWAC Report 1998.

Table 1 illustrates the numbers and average ages of registered and practising midwives by State and Territory; the vacancies known to exist, and in some cases the students needed to maintain the workforce. It is drawn from several referenced sources and by combining available published data it provides a representational overview of the situation. It is not a quantitative measure of the current workforce and should be viewed only as a crude estimate.

**Table 1. Available data to illustrate numbers and average ages of registered and practising midwives by State /Territory in Australia 1995-1999**

| | NSW | VIC | QLD | WA | SA | TAS | ACT | NT |
|---|---|---|---|---|---|---|---|---|
| #Births | 86,263 | 62,732 | 47,864 | 25.090 | 19,310 | 6,682 | 4,830 | 3,607 |
| Registered Midwives | ϕ10,400 | ***13,347 | ♣8,125 | ϕ2,814 | ♦ | *870 | ♦ | ♦ |
| Practising Midwifery | ϕ3,044 | †3,566 | ♣2,600 | ϕ931 | §1521 | ϕ357 | ±343 | ϕ167 |
| Vacancies | ϕ90 | ♦ | ♣128 | ϕ66 | ♦ | ♦ | ♦ | ϕ37 |
| Average Age | ϕ35-39 | **40-49 | ♣41 | ϕ42.7 | §40 | ϕ45 | ♦ | ♦ |
| Students needed | ϕ320 | ♦ | ♣180 -200 | ϕ70 | §109 | ♦ | ♦ | ♦ |

Sources:; #AIHW 1998; ± AIHW 1999 Nursing Labour force 1998; ϕAMWAC Report 1998; ♣Qld Health 1998 Midwifery Workforce Planning for Queensland; **ACMI 1999 Reforming Midwifery; ***Nurses Board of Victoria Annual Report 1998; †Victoria Department of Human Services 1999 Nurse Labour force Projections Victoria 1998-2009; § Rawinski et al South Australian midwifery training Requirements 1997-2001; *ACMI (Tas) 2000; ♦ Data unavailable

The Australian College of Midwives Inc. estimate the actual number of registered midwives in Australia to be about 70,000 (ACMI 1999). This figure is taken from registers held by the state and territory Nurses Boards and does not reflect the actual or even potential midwifery workforce. For example the Nursing Labour Force document for 1998 cites 28,125 employed registered nurses who identified practice skills used in the past five years for longer than twelve months as 'midwifery skills' (AIHW 1999). The same document also reports the number of registered and enrolled nurses employed outside nursing to be 9,094 in the same year. The recently completed "NSW New Graduate Study" reports that 30% of newly qualified midwives did not seek midwifery related employment on graduation (NSW Health 2000). Historically and until recently, midwifery was commonly undertaken in Australia as a second certificate in nursing not necessarily with the intent to practice as a midwife (Barclay 1995).

The information held by the state Nurses registration boards pertaining to actual numbers of registered midwives and practising midwives is collected for the Australian Institute of Health and Welfare and is not freely or publicly available. The latest published data on the nursing labour force from the AIHW reported in 1999, includes a table with percentages of registered and enrolled nurses employed as 'clinicians' in Australia. The figures quoted for nurses clinically based in midwifery are 13,209, or 6.7% of the registered and enrolled nurse force (AIHW 1999). The difficulty with this data is that it is not possible to separate out those nurses who are enrolled nurses practising in the area of obstetrics and maternity nursing, those who are registered nurses practising obstetrics and those who are registered or certified midwives practising midwifery.

## Calculating the numbers of midwives needed using a rudimentary model.

Currently there are 3,000 midwives who are members of the Australian College of Midwives Inc., and the College believes their membership to be approximately 30% of all practising midwives. This estimate suggests there could be possibly 9 - 10,000 midwives at present in Australia, a significant number of whom are employed on a part time basis, who report their main area of work as 'midwifery practice'.

A projection of the number of full time equivalent midwife positions needed in Australia is based on the known statistic of 249,600 live births (AIHW, 1999). Allowing for one full time midwife in practice per 40 births, the estimated number of full time practising midwives needed to provide services for these women alone would be around 6,500. A number of midwives are also employed where their midwifery knowledge and skills are necessary, in teaching, neonatology, gynaecology, women's health, early childhood services, family planning and research. In addition, a group will move into leadership through management positions.

We undertook a rudimentary modelling exercise, which built in attrition rates of 10% and part time employment based on 25% of the workforce. The attrition rate is lower than the 30% attrition rate found in "The New Graduate Midwives Survey" undertaken by the NSW Health Department (NSW Health 2000). The part-time estimate is also more conservative than figures from the nursing workforce data showing only 42.9% of registered nurses employed in midwifery, obstetrics and gynaecology were working full time (AIHW, 1999); or the AMWAC Report 1998 showing only 47.0% were working 35 hours or more; or a recent study of practising midwives in Victoria showing only 27% in full time work and 73% in part-time employment. (Watson et al 1999).

We based our calculations on the need for 8,558 midwives just for direct clinical midwifery care (excluding gynaecology and obstetric nursing). This figure agrees broadly with some of the other estimates that were made using New South Wales's specific data (NSW DOH, 1996). We estimate we are currently educating about five hundred and fifty (550) student midwives in Australia. This is based on estimates of 22 pre-registration programs with an average of 25 students in each course (AMAP figures 1999).

Using a conservative estimate of 10% of the current workforce needing to be educated annually to maintain a steady supply, and 10% more needed to cover attrition, and assuming 8,558 midwives are needed to fulfil the needs of clinical services, the number of students required in programs today would be around nine hundred and forty (940). Our conservative, 'best estimate' suggests we are currently educating 550 students, which is less than two-thirds of the number required. The recently released "New Graduate Midwives Survey" confirms that 'the pool of new graduate midwives supplying the midwifery workforce is considerably less than the predicted numbers required to adequately sustain the workforce' (NSW Health 2000 p 7).

There are further complications in basing estimates on student numbers because of the difficulty in separating out overseas students from those who intend to work in Australia. We cannot determine the actual number of overseas fee paying students in midwifery programs at present, although we know that 46.4% of students commencing post-basic nursing courses in 1998 were overseas students (AIHW, 1999).

## Issues in rural Australia and in particular concerning Indigenous midwives

Rural and remote Australian women are suffering most as a result of shortages of midwives according to health service leaders and Government figures showing regional skill shortages (Serghi 1998). Where maternity services have been closed down it is socially disruptive, expensive and distressing for Anglo Australian women to travel great distances to larger centres. However, the results for Indigenous Australians show up even more starkly in statistics. Data on the health of Indigenous mothers and babies demonstrate a crisis in providing acceptable services for these people. Although there have been reductions in infant and maternal mortality among Indigenous people, the differential in birth outcomes between the Indigenous population and other Australians has not been eliminated. The proportion of low birthweight babies (under 2500 grams) born to Indigenous women has remained two to three times higher than for non-Indigenous women (ABS 1997, AIHW 1998). Similarly the stillbirth rate and the death rate for babies in the first 28 days of life are two to four times higher (AIHW 1998). In the Northern Territory the perinatal mortality rate for normal birthweight babies of Indigenous mothers is 20 times greater than that of babies of non-Indigenous mothers (Markey et al 1996). Other States also report alarming differences in perinatal mortality rates between Indigenous and non-Indigenous people (ABS 1997, Crowley 2000).

Three of the most recent reports on health and birthing services available to Indigenous women draw consistent conclusions and make similar recommendations (Kildea 1999, Hecker 2000, Standing Committee on Family and Community Affairs 1999). They include:

- an acute shortage of midwives and inadequate numbers of Indigenous people training to become health workers and health professionals. Although more than 40% of Indigenous people live in either rural or remote areas of Australia (AIHW 1998), 42.1% of nurses employed in these areas are enrolled nurses compared with 26.8% registered nurses. (AIHW, 1999).
- a lack of educational opportunity for Indigenous health workers and maternal and child health workers to be educated as midwives (Kildea, 1999, Hecker 2000).
- a need to build better links between Aboriginal women, support people and labouring women (Kildea 1999, Hecker 2000).

Nearly 30% of Indigenous mothers from remote communities have to travel away from their home location to give birth (Markey et al, 1996). This is not a problem in some places where cultural needs are fully met (Brodie 2000). However, for many women the loneliness of the separation from families, and the fear of strange surroundings are overwhelming. Many Aboriginal people fear that if they give birth somewhere other than on their homeland they may relinquish rights of traditional ownership (Kildea 1999).

The discussion paper from a recent Inquiry into Indigenous Health suggests that 'a vertically integrated system for the recruitment, education and training of rural and remote health professionals should be developed, based on the collaboration of governments and training institutions' (Standing Committee on Family and Community Affairs 1999 p20).

Similarly, a report on equity issues and universities' inclusion of Indigenous Peoples' rights and interests, funded by the Commonwealth government, recommended that 'universities need to accommodate Indigenous interests and rights across all facets of their operations-teaching, research, administration and community service. This requires more than cross-cultural awareness training, the incorporation of Indigenous perspectives in the curriculum or the employment of Indigenous educators. There is a need to create a space from where efforts can be made to reflect and entrench Indigenous values and protocols across all sectors of the university. No doubt this raises questions about making fundamental changes to the core values and ethos of the university so as to ensure that Indigenous knowledges and Indigenous ways of relating, seeing and doing are included and

given legitimacy. This is not only about inclusion, it is also about acknowledging the sovereignty of Indigenous peoples' (Anderson et al 1998 p4).

Both the cultural and financial barriers to the training and education of Indigenous midwives are significant. The cost, duration and geographic location of the present midwifery training programs disproportionately disadvantage Indigenous women.

## The financial burden of postgraduate midwifery education: and the HECS

In 1996 the Higher Education Contribution Scheme (HECS) was altered and full fee charges were levied for the first time for postgraduate education. Midwifery is classified as a postgraduate qualification and therefore it now attracts full course fees. This places a considerable personal financial burden on nurses who wish to study midwifery, and affects both the recruitment and attrition rates of Australian students..

Disciplines were placed into differential HECS bands according to the cost of the course and on the average earning potential of graduates from those disciplines. Nursing was grouped with arts and education in HECS Band 1 with a $3,300 contribution. Despite the relative high cost of nursing education it was placed in Band 1 because of its relatively low earning potential. 'Other characteristics of the HECS arrangements were retained. That is, HECS is deferrable and payable through the taxation system-no qualified student would be prevented from entering higher education because of an inability to pay at the time of enrolment' (Andrews 1997 p17). However, in a later report, "Does HECS Deter?, Andrews found that only 19-21% of students entering Band 1 (nursing, education) were from low socio-economic groups (Andrews, 1999).

A recent discussion paper produced by DETYA stated that although the participation of women in higher degrees had increased steadily over recent years, this was mainly within HECS funded courses. The gains made by women in the postgraduate sector are tenuous because of the trend to reduce such courses (DETYA, 1999).

Similarly, Andrews found that while the level of (mature age) applicants from those entering higher education did not appear to have been affected by the introduction of HECS in 1989, they may have been subsequently affected by the changes in HECS funding. 'The number of mature age applicants is tentatively estimated... to have fallen by 10,000 persons or 10 per cent of mature age applicants due to the changes to HECS announced in 1997' (Andrews 1997 p 33). Analysis shows that the level of unsatisfied demand in the work place did not affect this fall in the number of applications from mature age students (Andrews 1997).

Many women and students from Indigenous and/or rural and isolated backgrounds are already either not making it into postgraduate study or facing financial hardship following further education (DETYA 1999). Research conducted by the Council of Australian Postgraduate Associations (CAPA) found that women in female dominated professions feel particularly disadvantaged by up-front fees where a relatively low level of employer support combined with low incomes pose serious equity problems (CAPA 1999).

## Current attrition rates in midwifery education

Although there are no published data specific to attrition rates within midwifery courses, Table 2 is derived from several tables showing completion rates of Australian students entering nursing education (AIHW 1999 pp. 20-23).

Reliable anecdotal reports from universities in New South Wales suggest attrition rates in some midwifery programs are as high as 25%, enrolments in some programs as low as 50% and overseas students may fill up to 25% or more of the postgraduate midwifery places in some programs. The current competitive climate makes this sort of sensitive information difficult to verify.

**Table 2. Percentage of Australian (permanent resident) students completing the basic and postgraduate courses in nursing in Australia from 1994-97.**

| COURSE | ENROL 1994 | COMMENCE 1994 | ENROL 1995 | COMMENCE 1995 | COMPLETE 1997 (%) |
|---|---|---|---|---|---|
| 3 YR Basic Nursing | 23,629 | 8277 | - | - | 5,323 (64.05) |
| Grad. Certificate | - | - | 321 | 301 | 324 (100.0) |
| Grad. Diploma | | | 2641 | 1843 | 1622 (88.0) |
| MA + | - | - | 1217 | 637 | 298 (46.0) |

Source: Nursing labour Force 1998, AIHW 1999

The addition of 23 in the Grad.Cert. course could correspond to those who were enrolled in a Masters course, but subsequently left to complete a Grad.Cert.

## Inconsistencies within midwifery education

There are a number of post basic midwifery courses on offer in the universities of Australia. It is apparent there is no overall consistency in design, duration or level of award both nationally or within each separate state. Examples are as follows.

- The Master of Midwifery course in one state has the prerequisite Bachelor of Nursing (three years general nursing) with a practising certificate and offers 'contact time' 208 hours.
- In the same state, a Master of Midwifery prerequisite is a postgraduate Diploma of Midwifery, with one years' clinical experience in midwifery (three years general nursing, one year to certify as a midwife, one year practising as a midwife). This program offers 'contact time' of 200 hours.
- In another state, a Master of Midwifery prerequisite is described as a nursing degree with one year's post registration clinical experience in nursing (three years general nursing, one year practising as a nurse) and offers 'contact time' 672 hours (Ashenden and Milligan 1998).

The ACMI advises that preparation for practice should be at graduate diploma level. However, a number of the programs that are attached to licensing are now offered at master's level, affecting both the duration and cost of the program (Barclay 1995).

At present there is no national monitoring system to guarantee comparability or an adequate baseline of competence. Not all states and territories have adopted the current ACMI midwifery competencies (NSW Health 2000).

## Retention of graduates through evidence-based models of care

In "Education Strategies for the Midwifery Workforce", a recently released draft document from the New South Wales Health Department, the tensions between the primary health care model and the realities of tertiary midwifery services were reported. 'In many cases services are not developed with sufficient attention to the expressed concerns of birthing women, population or epidemiological data' (NSW Health 2000 p25).

Research, including randomised controlled trials of midwifery care show that midwives offering continuity of care gain a significant increase in autonomy and work satisfaction (Flint et al 1989, McCourt et al 1996, Turnbull et al 1996, Rowley et al 1996). Where midwives care for women through the entire antepartum, intrapartum and postpartum episode, the maternal and fetal outcomes have been found to be safe, less interventionist and more satisfying for both the woman and the midwife involved (Flint et al 1989, Hueston et al 1993, Kenny et al 1994, Rowley et al 1995, Turnbull et al 1996, Harvey et al 1996, McCourt et al 1996, Waldenstrom et al 1998, Guilliland et al 1998, McDorman & Singh 1998, Hodnet 1999,Homer et al 2000) . Continuity of care models encourage midwives to use their skills cross community and hospital settings. Being based in the community provides a viable option for rural settings in Australia instead of the more costly 'roster

based' system within hospitals. It encourages a greater emphasis on 'problem prevention' and health promotion through community-based antenatal and postnatal care. This model of midwifery care is ideally suited to outcome based funding as opposed to fee-for-service funding.

## Strategies to address the labour force shortfall through midwifery education

The first and most obvious strategy is to remove the postgraduate fee attached to midwifery education. Preliminary research suggests this is a major barrier for registered nurses.

A second strategy is to offer a three-year Bachelor of Midwifery (B Mid) or undergraduate midwifery degree program without the pre -requisite three-year nursing registration. (This is completely unrelated to the 'direct entry' midwifery program of thirty years ago which was a program of limited nature and has persisted in negatively influencing the perception of 'direct entry' education in Australia for the thirty years since the program was phased out (Barclay 1995).

In the last decade there has been resurgence in undergraduate degree programs in midwifery. The UK now prepares the majority of midwives in comprehensive three-year undergraduate degree programs (ENB 1997). Other Western countries have demonstrated a long-standing and more consistent commitment to specialist degree courses in midwifery; for example the Netherlands, France, Denmark and Canada offer midwifery education only and not as an 'end on' to nursing. In each of these countries undergraduate education to degree level for midwives is considered standard practice. New Zealand and the UK currently offer a dual route of preparation for nurses and non-nurses, however a number of universities plan to close postgraduate nursing midwifery courses in favour of the direct entry model (DOH 1998, Pairman 2000).

## The context of innovation and improvements in midwifery education

Any changes in the current situation must consider the economics of a contracting funding base for the university sector. Nursing education, and by inference, midwifery education, has a high cost factor and a relatively low earning potential (Andrews 1999). If midwifery undergraduate programs were introduced they would share core subject teaching across midwifery and health programs. For example pre-registration midwifery graduates could move into shortened general nursing pathways, and to post graduate education in either nursing or midwifery. The BMid program would educate midwives who can provide a breadth of practice across tertiary, remote and rural areas.

The needs of women who seek low intervention, midwifery models of maternity care also have to be considered. A recent Senate Inquiry in Australia found that the availability of birth centre facilities are so limited for women in many areas, they are required to submit to a 'ballot' system, or a lucky draw to gain access to these birthing facilities (Crowley 1999). New models of education for Indigenous midwives would begin to address the alarming problem of poor outcomes in maternity care for Indigenous women and their families (Hecker, 2000).

A government-funded national review of specialist nurse education in Australia in 1997 revealed a range of factors to take into account in the planning and delivery of specialist nurse education in order to meet changing community and workforce needs. Amongst the main findings, it was recommended that 'the following factors be taken into account by the health and higher education sectors, government and the nursing profession in the planning and delivery of specialist nurse education:

- changing nature of health care delivery within the Australian community;
- emergence of new areas of nurse specialisation which meet the criteria given above for approval of nursing specialties;
- future development/s of the role/s of nursing specialists;
- demand by potential students in conjunction with workforce requirements (that is, market forces); and

- appropriate spread of nursing specialist programs across Australia in terms of: demographic trends and geographical location' ( Russell et al 1997).

The "New Graduate Survey" recommends that Area Health Services work with universities to ensure that midwifery education programs meet service needs (NSW Health 2000).

## An undergraduate degree program in Midwifery - Bachelor of Midwifery (BMid)

A proposed undergraduate degree program in Midwifery (direct entry midwifery) is one way to address issues of cost in postgraduate training of midwives. It will produce graduates in three rather than five plus years and will not attract current postgraduate fees. In countries other than Australia, where the Bachelor of Midwifery is the preferred education model for midwives, course enrolments are at full capacity while attrition rates have fallen significantly. (Page 2000, Pairman 2000).

Although several Australian university nursing schools are opposed to the concept of an undergraduate degree for midwives, the Victorian branch of the Australian College of Midwives in collaboration with women and consumers paved the way for public discussion with their release of a comprehensive discussion paper called "Reforming Midwifery" (ACMI Vic. 1999). A meeting was called in Adelaide in December 1999, to 'launch' the BMid. All interested universities were represented in the initial working party to consider the philosophical, professional, strategic, educational and financial gains to be had by launching the first B. Midwifery courses simultaneously. There was a unanimous vote to proceed in a unified manner to establish national guidelines for the new midwifery education. It was also agreed the standards would be implemented in partnership with the regulatory authorities.

Following this meeting the Australian College of Midwives released the following press statement on the 28th April 2000. "An ACMI Taskforce composed of midwifery educators from each state and territory has been formed to oversee the development of consensus guidelines that will form a national framework for the introduction of Bachelor of Midwifery education programs across Australia. This national framework will establish and articulate professional standards for the accreditation of the three-year Australian Bachelor of Midwifery (BMid) programs. These programs will enable graduates to practise competently in a range of settings within the full scope of practice defined by the International College of Midwives. The purpose of the national framework is to establish and articulate professional standards for the accreditation of Bachelor of Midwifery (BMid) programs that will proceed with the support of the Australian College of Midwives" (ACMI 2000).

The professional and political environment has to support the need for urgent action on the midwifery component of our maternity care workforce. In Australia we cannot continue to operate in professional isolation and risk the consequences of remaining out of step with the developments of our profession internationally. The proposal for a B Mid is likely to confront those who believe that midwifery is only a post nursing specialisation. Therefore the process will require both politically sensitive and respectful negotiation. The recent licensing of a number of overseas-educated 'direct entry' midwives in a number of Australian states has, however, already forged the route for registration for pre-registration, undergraduate degree midwifery students. To highlight some of the discrepancies occurring at present, overseas educated midwives who are not trained as nurses are required to register as 'nurses' to work as midwives. This assumes some competency in nursing for which they have no educational preparation.

## Conclusions

There are three overriding factors that influence our current crisis in the shortage of midwives and problems with midwifery education. Firstly, it may take five years and considerable cost to the student and the university, to produce a beginning practitioner through our postgraduate educational pathways.

Secondly there is an urgent need to increase the number of midwives. The shortage of midwives is a global problem and Australia can no longer rely on migration from other countries to correct the serious shortfall. Already there is a substantial 'waiting list' of prospective students eager to enrol in the new Bachelor of Midwifery program (Leap, 2000)

Thirdly there is a serious lack of culturally appropriate midwifery training at tertiary level. The tension to be addressed in Australian higher education is, 'what is the balance between Indigenous peoples' desires for autonomy and self-determination and the overall institutional commitment to ensuring that those efforts are realised within the federated structures of universities' (Anderson et al 1998 p 9).

Research is essential to guide developments in Australian maternity care. A national database of midwifery courses and students is required to monitor trends and predict supply.

Further investigation is needed to assess the direction and quality of education for midwives, recognising an increasing use of new models of care. Midwifery models based on evidence of safety and cost effectiveness promote communication and co-ordination between health care professionals, linking hospital and community care. They are more clearly focussed in primary health care rather than hospital illness or trauma. Midwives educated through pre-registration undergraduate degree programs with a social/family-oriented approach to care practice in collaboration with medical colleagues and other health providers, in all aspects of maternity care.

Australia's lack of Indigenous midwives working within remote and urban communities needs to be addressed urgently. Education for midwives through pre-registration undergraduate degree programs that provide Indigenous communities with their own midwives could contribute significantly to improving perinatal health care for mothers and their infants. Such an initiative would reduce the social disruption to remote area women who are transported hundreds of miles to give birth to their infants.

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# Midwifery: A profession in transition

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## ABSTRACT

This study sought to explore midwifery self-identity in relation to two major, competing discourses - medicine and midwifery. In-depth interviews were conducted with twenty-two midwives working in different settings. Although the study was exploratory, the findings showed conclusively that midwifery is not a static, discrete body of knowledge (Commonwealth Department of Human Services and Health 1996); nor should midwifery be seen necessarily falling neatly into one stream or another (Davis-Floyd 1992). Rather, midwifery is a discursive practice (Kent 2000). The midwife (like the obstetrician and nurse) trawls through a range of discourses (or ways of understanding and knowing) about the body and childbirth in order to construct their own practice. Midwifery is a fluid process of subject formation which changes over time according to age; experience; and setting of practice (private or public hospital, birth centre or home). Of primary significance is the way midwives viewed the body. Few midwives fell into either the medical (obstetric assistant) model or the midwifery (professional, independent) model. Most midwives could be classified 'hybrid' in the sense that their clinical practice drew variously on each of the major discourses according to contextual factors.

### Professionalising strategies: what is the best way to go?

Midwifery in most Western regimes became controlled by male practitioners when medicine professionalised at the turn of the twentieth century. It was then that medical professional bodies constructed midwifery standards effectively putting limits on midwifery practice and cementing the supremacy of medicine as a vehicle of authority, not just in medicine, but in the realm of the morality of everyday life. As Foucault (1973) has demonstrated, medical dominance has been a strategy of broad social control in Western societies since the Enlightenment. The dominance of the scientific paradigm also became institutionalised in law, medical recruitment and clinical practice in hospitals (Willis 1989). One consequence was the medicalization of the body and of social life. Thus, birth was constructed as dangerous. If birth was interpreted as inherently uncertain, then obstetrics became the science of making it certain, of bringing it under the complete control of the scientific gaze (Murphy- Lawless 1998:19). Experts with exclusive access to surgical, chemical and medical resources were needed to extract the baby from the site of risk - the mother's body. For this reason, medicalized birth is described as a separation model of childbirth (Davis-Floyd 1992).

Over time, the traditional midwifery model of knowledge - a model based on experiential, intuitive and practical skills - became subordinate to the rational, scientific and highly codified knowledge of the doctor (Kent 2000:28). It was 'a triumph of propositional knowledge [knowing that] over practical knowledge [knowing how]' (Dalymia and Alcoff 1993:223). In short, medical strategies of professionalization within high-income nations in the Western world stigmatized midwifery knowledge and relegated midwives to supporting roles.

### What has been the midwifery response?

The midwifery response has been to professionalise the occupation; at different rates in different countries. In Canada, the UK, The Netherlands and Germany, states intervened to foster professionalisation, consumers supported midwifery autonomy and midwives based their professional practice and identity on the one crucial difference

with obstetrics - the ability to provide continuity of care and homebirth (Sandall et al 2001). However, the regulation of midwifery by obstetrics through Nurses Boards and university curricula course committees ensured that midwifery inevitably remained subordinate. This was aided by economic rationalist employment policies that deployed midwives in one of three specialised fields (antenatal, delivery or postnatal wards) thereby fragmenting midwifery knowledge and the midwifery skills base. Ironically, and unjustly, medical management has largely failed to achieve superior outcomes in terms of mortality, morbidity and maternal satisfaction measures. Indeed, the reverse is the case: midwifery practice and midwifery 'knowledge' result in better mortality and morbidity outcomes than obstetric care (Tew 1990; Hodnett 1999; Kenny et al 1994; McCourt et al 1998; Rowley et al 1995; Oakley, Hickey and Rajan 1996; Roberts et al 2000).

Predictably, the claim to professionalisation of midwifery in Australia has been conducted on the grounds of midwives' special 'partnership' relation with women within a holistic, 'wellness' model of care. Although nursing is holistic, it adheres to a medical, or illness model. As a professionalising strategy, therefore, midwifery has claimed a discrete conceptual domain on the grounds that it is woman-centred and deals with 'normal' birth. By association the woman is not a 'patient' (pliable, compliant and naïve) but a partner in the entire process (Guilliland and Pairman 1995; Davis-Floyd 1992; Wagner 1997).

This does not mean that all midwives want to exercise autonomy from obstetric monitoring, nor that they would all seek to provide around the clock one—to-one care, especially those with pressing domestic responsibilities of their own (Benoit 1987; Sandall 1997). It is also the case that some midwives simply do not depart from the basic premises of obstetric science. The present study sought to understand to what extent midwives in Australia embraced either a wellness, social model of birth as opposed to an illness, medical model of birth characteristic of obstetric science. We may understand these two bi-polar positions by recourse to the following ideal-typical models of knowledge.

## Competing models of knowledge

The medical model of the body or an **objectivist** approach assumes that knowledge (by the doctor) is separate from the object of the knowledge (the patient's body). The doctor is the expert with the knowledge of the patient's body, while the patient is ignorant and subject to the expertise of the other (Rothfield 1995: 174-180). Further, the hospital and the clinic institutionalise both the doctor's knowing and the patient's ignorance. This realist ontology is called positivism because it is assumed that the truth is posited externally. The way to discover the 'truth' would be to conduct a survey questionnaire which documented a large number of responses to standardised questions from which could be drawn universal laws which could then be tested through other studies to achieve validity, reliability and generalisability (Angen 2000).

A **productivist** approach to knowledge and the body, by contrast, assumes that knowledge or reality is constructed through our interactions with each other. (Rothfield 1995: 174-80). It is a social model of birth. In other words, there is no 'God's eye view' of the world, or an external objective reality against which other non-truths may be evaluated because we construct knowledge or reality out of our social interactions. There is no knowledge of the world separate from our interpretation of it (Angen 2000). In this approach, there is no right or wrong, true objective or non-validated subjective knowledge, but merely ways of knowing or discourses.i Our interpretation will be shaped, in turn, by the social forces and institutions, including language, surrounding us and our interaction with them. Appropriate methodologies to discover the meanings or interpretations that individuals impose on events would be open-ended interviews or focus groups (Angen 2000).

## The Study

The study was conducted in 1998 and comprised open-ended interviews with twenty-two midwives. Initially, a request was made to a large public hospital in regional Victoria (Australia) to interview midwives. No reply was received. I also ran an advertisement in a midwifery professional journal, but only one midwife agreed to join the study. The sample was thus obtained by a 'snowball' method - by word of mouth among midwives in the region working among a range of settings which included a large public hospital, a large private hospital and the community. The study analysed material from in-depth, unstructured interviews lasting approximately 1 1/2 hours. Midwives were requested to describe an 'average' birth and then asked why they thought approximately 89% of

women in hospitals would have some kind of intervention. The respondents talked at length about the social context of interventions (conversations between medical staff and the mother); why they thought interventions had occurred; whether they thought the interventions were justified at the time; how they thought women felt about interventions and their own views on intervention during childbirth. In essence, the midwives reflected upon the nature of the body, the medical and social models of birth, and their own construction of childbirth.

The interview material showed that midwives ranged along a continuum with the two 'pure' models at either end. Each midwife will construct a unique set of practices shaped by her own lived experiences including where she works, the extent of her clinical experience, her training, her own birth and how she understands the medical model. In practice, few midwives fit either of the 'pure' models. Most could be classified in what is called here the 'hybrid' category.

### Obstetric-assistant midwifery

These midwives saw women's bodies as inherently fragile and requiring intervention because bodies very often fail to perform adequately. Since the body is a biological, universal entity, definite timeframes could be applied to judge normal and abnormal births. A non-interventionist birth depended entirely on the mother's physical competence. For Patricia, a normal birth conforms to a strict time frame. If not, intervention will be necessary. This is a realist ontology. Knowledge of the body is comprised of objective scientific facts with minor if any credence given to the view that the woman's social construction of the environment will determine bodily performance.

> *They say approximately 1 centimetre an hour from the time they are 3 centimetres. So that means once they get to 3 centimetres it should only take roughly another 7 hours to get to full dilation which is 10 centimetres and to the actual delivery it can take 2 hours because they can get to full dilatation but sometimes the head has to do some descending. The woman will push it out and that is all normal. With a multigravidae (a subsequent birth) the progress is much quicker. Once they get to around 5 centimetres on it is a downhill run. ..... Once they are over 2 hours .... some intervention is necessary. ...you do the time frames because prolonged labour causes difficulties both for the mother and the baby. .....I find thin people do well. And the younger they are the better. The young ones under 25 having their first do quite well.*

The notable aspect of this evidence is the view that intervention occurs when the body is not functioning properly because of some physiological defect - age, body fat, pelvic size or diabetes. Power relations in the birthplace are considered to be unimportant in terms of bodily functions. That intervention rates are much lower for professional midwifery models of care which prioritise personal control and a tension-free environment is lost on 'obstetric-assistant' midwives. When questioned further about high statistics of intervention around augmentation and forceps, Patricia attributed this to the mal-presentation of the baby - still an explanation of physical incompetence, but now it extrapolates to the baby's body: This approach is said to be based upon a positvist or realist ontology because it assumes a 'givenness and independence of reality'. In other words, there is an objective reality separate from our knowing it: knowledge is posited (rather than socially constructed). We may use our sensory perception of the world to provide us with accurate data from which we may derive general laws or patterns of cause and effect (Angen 2000). When extrapolated to childbirth, any labour and birth may be plotted against the 'general law' of the 'normal' birth. Any deviation from the 'norm' will be treated as a risk and intervention must follow, as Patricia believes is necessary when women 'go over time'.

## AUTONOMOUS MIDWIFERY

'Autonomous' midwives define themselves as relatively autonomous from both nursing and obstetrics. For them, the body is 'elastic' (Grosz 1994) because it responds appropriately to the mother's perception of the social context. If a women is fearful and insecure her body will not dilate. These midwives more obviously adopt a 'pure' version of the productivist theory of knowledge and subjectivity.

Judith is an 'autonomous' midwife. She practised independently and implicitly used a productivist model of knowledge. She believed that much intervention was due to the imposition of

unrealistic and artificial timeframes during labour. According to her, all labours will be different because all women process social discourses differently and this will variously affect their labours.

*Judith: Women come into the hospital system by invitation or by themselves when they are probably pre-labouring. .... The intervention starts because this woman has been in here now this many hours and she really hasn't progressed. .....Then they start talking to her, "Maybe we should induce you now. Really, if we ruptured the membranes we could get your contractions going because you could go on for hours like this". Within the hour a drip will go up and then she is having uterine action which is forced upon her by a drug that doesn't offer her any contractions like she would be having if she was doing it with her own physiological function. Then she gets distressed so she is offered pain-relief - usually Pethidine. Pethidine doesn't stop the pain but Pethidine puts you in another pain which then puts you out of control. So then they are asking for an epidural - they are pleading for help and so they get the epidural and of course then they are pain free. Then of course they flatten their back with monitors so the progress of labour is impeded further because of the actual position and then that often leads to foetal distress because of the intensity and acceleration of the labour. ...At the same time she gets the adrenalin rising too because she is frightened in the situation she is in.*

For Judith, an ordinary (that is, idiosyncratic) birth was labelled as pathological on entry to hospital. The woman gradually devolved from a position of calm and relative control into a state of tension, then loss of control, and finally, disorientation and subordination. The essence of this construction of childbirth is that physiological changes occur in response to the woman's perception of the social environment, not the reverse as is the case for 'obstetric-assistant' midwives. Finally, 'autonomous' (productivist) midwives look for causes of bodily changes in the social and historical context. For them, the body is not just a biological entity, nor merely a set of chemical and muscular reflexes, but a fairly malleable or 'plastic' resource (Grosz 1994). The body represents the sum total of our social interactions. The woman will bring with her a preconceived way of understanding derived from her own social history, including broad sociological factors such as gender, class, ethnicity, age, sexual preference and geographical location. These will be operative in the birthplace and affect physical functioning as is evident from the above narrative.

## HYBRID MIDWIFERY

'Hybrid' midwifery was the largest category. These midwives draw on both the productivist and objectivist models. Sarah believed that how women constructed reality would impact upon bodily performance.

> *If women were just left to labour with the support they need possibly there would be less intervention I think. .... A lot of them feel out of control even before they have their first contraction. Frightened to bits of the actual thought of pain. ... If they are not relaxed they are not letting their body do what nature is making it do. If they are trying to hold it back obviously things are going to slow down..... There are plenty of things to do. There is massaging. You can suggest position changes, You can suggest a shower, hot packs, the medi ball. We suggest a lot of non-medicinal type ways of helping them cope. Just being there, talking to them, holding their hand, stroking them.*

In this case, Sarah understood that physiological changes were related to emotional states and that the social context was vital in disrupting or restoring an emotional and thus physical equilibrium. Her job, being 'with woman', was to avoid intervention. So far, she adopts the major premise of the productivist model - that in the vast majority of cases there are not faulty bodies but bodies that respond appropriately to a social context. If women are frightened, their bodies will not function properly. (Ironically, this will provide the legitimation for the medical premise of the inherently faulty body and the need for medical intervention). Then Sarah says that if intervention does occur it was because the woman's body had become incompetent. She then reverts to the objectivist premise that bodies are inherently faulty.

> *I would say the doctors have to intervene if the women are not progressing for one reason or another. Their bodies are not dilating. It could be that the baby is distressed or it could be that the patient is in pain.*

In short, 'hybrid' midwives believe that birth is natural and that much intervention is precipitous. However, they have contradictory views about the body. On the one hand, they respect the agency of

women and lament women's subjugation under a culture of medical dominance. They also understand that how women perceive the social context exerts a profound influence upon their emotional, psychological and physical states. A negative perception will critically impede physical performance. However, they switch almost seamlessly into an objectivist world-view that accepts a disembodied subjectivity or, in Descartes terms, a mind/body split. When bodies fail, which they commonly do, it occurs for purely objective, physiological reasons. Then obstetricians are obliged to intervene.

## CONCLUSION

Midwifery is a fluid process of subject formation with a set of shifting empirical practices. Factors which influenced midwifery subjectivity included age; experience; setting of practice (private or public hospital, birth centre or home); and, significantly, the way in which they viewed the body. 'Obstetric assistant' midwives and 'professional autonomous' midwives comprise minority categories. 'Hybrid' midwives hold contradictory models of knowledge about the body. Much intervention is thought to be routine and unnecessary because the body is mediated by language and culture. However, they often switch seamlessly into an objectivist view, regarding the body as pre-social and biological when labour not does progress according to plan.

The findings suggest that professionalisation of midwifery is still in its infancy. Midwives need to ask themselves how much autonomy they wish to exercise in their practice and how they understand the relationship between the body and society. Educators need to incorporate material on theories of the body and society into their curricula with particular emphasis on distinguishing between realist and social constructionist theories of knowledge. Providers may need to institute a two-tier system of midwifery care accommodating two broad philosophical streams (Sandall 1997) and even multiple models of practice to suit both midwives and a range of women's needs (Lazarus 1997).

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[i] A strong critique of qualitative methodologies is that they lead to extreme forms of relativism, where there is no way to validate or prioritise any discourse above another. However, Angen (2000:9-10) argues that qualitative methods may achieve validation (as distinct from the positivist validity) through either ethical or substantive processes. Ethical validation means that the study has made us 'more sensitized to, or enlightened about, the human condition because of the research'. Substantive validation means that 'researchers must show how they have done justice to the complexity of their chosen topic by bringing into play all the various, present and historical, intersubjective understandings of it. This process includes a consideration of one's own understandings of the topic, understandings derived from other sources, and an accounting of this process in the written record of the study'.

# Difficult labour: struggles to change Australian maternity care

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**Abstract:**

The basic structure of Australian maternity service provision emerged during the early decades of the twentieth century as part of a complex set of historical struggles. This paper establishes the ways in which the resulting framework continues to shape contemporary services and identifies changes, continuities, and barriers to reform efforts in recent decades. The increased role of the medical profession in managing childbirth came to be supported by the state and accepted by the public. It was entwined with commitment to maintaining doctors' private practice model and with individual or family responsibility for payment for care. Public provision was only for the poor. The political struggles over health insurance and federal-state relations, and the eventual incorporation of midwifery within nursing laid the basis for an obstetric model of care which located childbirth in acute health settings. Attempts to change this model in the later twentieth century have used government inquiries and consumer action but only succeeded in providing some modifications of, and limited alternatives to, the basic framework . Current maternity policy is fragmented and affected by recurrent organisational restructuring and inconsistent information exchange. The paper argues that there are several major explanatory factors in the mix of change and continuity in Australian maternity care. They include the complexity of state–commonwealth relations and health financing and lack of political will to change maternity care—especially in the face of dominant medical interests and organisational restructuring in new market state of the 1990s. Only by understanding the intersection of these factors can effective change strategies be formulated.

## Introduction

Health services in Australia have been the subject of extensive study by economists, political scientists and sociologists. Most of the focus has been on the period since the mid-1970s when a national health insurance scheme, at first Medibank, then later redeveloped as Medicare, was instituted after considerable debate and dissension. It is common to find Australia's health system described as a 'strife of interests' (Sax 1984), but that is undoubtedly a feature of most contemporary health systems. What then might be distinctive concerning Australian arrangements, and what are the implications of the overall structure of health service delivery for maternity services? A national picture is difficult to achieve in view of State and Territory differences and lack of information on policy initiatives at local levels. This paper argues that analysis of historical factors and of the structural context affecting contemporary maternity policy is essential to understanding why struggles to implement change continue to be 'difficult labour'.[1]

Maternity service provision, or the social 'design of birth', always reflects historical, national and cultural factors (Davis-Floyd & Sarjeant 1997; De Vries et al. 2001). The particular historical development of Australia as a British settler society has shaped the organisation of health services, including maternity care. Australian patterns have been subject to influences not only from Britain but also from North America, and by the exigencies of quite disparate populations. On the one hand, an increasingly ethnically diverse white population is spread across a far flung country, but is primarily concentrated in urban areas, largely in the south-east of the continent. Rural and remote health care, including provision for Indigenous people, presents quite different challenges from that of the major metropolitan centres where most of the population is based. The geographical position of Australia, and the dynamics associated with British settlement and later immigration produced a health system which reflected a strongly individualist ethos in medical practice, yet also a significant role for the state in supplying infrastructure. Political factors, especially the complexity of funding and authority relationships between the three layers of government, local, state and federal, have produced fertile ground for interest group lobbying. It is difficult to gain effective national information let alone ensure equitable provision. All these factors impinge directly on maternity care, no national picture of which is readily available in spite of some recent inquiries contributing new information about present developments and issues (e.g. Senate Community Affairs References Committee 1999).

Patterns laid down in the early twentieth century, particularly medical dominance and a mixed pattern of public and private provision, continue to bedevil attempts to reform the management of childbirth in the last two decades. There are several major explanatory factors in the mix of change and continuity in Australian maternity care. They include the

[1] This paper arises out of the author's involvement in the Australian Midwifery Action Project (AMAP), research which was funded from 1999-2002 by a grant from the Australian Research Council's Strategic Partnerships with Industry scheme and contributions from industry partners. Feedback to the author will be welcomed, and the assistance of Dr Karen Lane in undertaking some of the recent data collection and commenting on the draft is gratefully acknowledged.

complexity of state–commonwealth relations and health financing, lack of political will to change maternity care in fundamental ways – especially in the face of dominant medical interests, and a relatively weak, geographically dispersed and often divided consumer movement.

## HISTORICAL BACKGROUND: PRE WORLD WAR 2

A comprehensive historical overview is beyond the scope of this paper but certain salient points can be drawn out to lay the groundwork for analysis of more recent developments. It is notable that in the many fine accounts of Australian health services, very little attention is paid to maternity care. Neither childbirth nor maternity services are indexed in major texts such as that of Sax (1984) or Daniel (1990), and Crichton provides one reference, but that to a single paragraph. Several historians have provided analyses of particular hospitals (e.g. McCalman 1998), but the only work of Gillespie (1991) and Thame (1974) in particular offers the basis for an overview of the historical development of the Australian health care system as it pertains to maternity care. Several issues recur, including debates over funding, the influence of medical practitioners on health policy, and contests over the role of midwives and nurses.

In the first decades after Federation, tensions emerged between politicians' and doctors' grudging acceptance of state provision for public health, especially with regard to quarantine and urban hygiene, but their resistance to state financial support for primary health care. This remained largely controlled by a medical profession determined to maintain their freedom and a system of private, fee-for-service practice. Doctors engaged in many battles over funding arrangements with state and hospital authorities and with the voluntary-sector friendly societies (Gillespie 1991). Under the federal Constitution, health care was designated a State responsibility, and has remained so in terms of actual provision of acute and some public health services. By the 1920s, however, a Federal Department of Health was established, oriented initially to overseeing national public health measures, especially quarantine. In the post WW2 decades, funding demands outstripped the revenue-raising capacity of State governments. The Commonwealth's financial role expanded considerably but administration and responsibility largely remained at State level. The resulting cost-sharing and cost-shifting activities, along with distinctive patterns of State organisation of health services, make up an intricate web. Most analysts of Australian health care arrangements point to their complexity and intensely political and historically contingent nature (e.g. Grant & Lapsley 1983, 1992; Sax 1984; Crichton 1990; Daniel 1990; Duckett 2000). Most importantly, the tension between the medical profession and the state continued, although its significance for maternity services has not been explored.

### Maternity provision

In the Australian colonies, doctors acquired considerable social prestige as they were amongst the educated elite and were also in short supply. Debates over the nature of medical training which characterised North America did not take on the same vehemence and the British Medical Association's promotion of allopathic medicine won support from state authorities with little opportunity given to alternative practitioners (Gillespie 1991: 5). In the early decades of the twentieth century, financing of primary health care

was contentious. Doctors, concerned to establish themselves in general practice, reluctantly relied on the 'panel' system whereby the friendly societies' working-class custom assured them a basic income on top of which they built up a private practice with more affluent clients. Gillespie documents continued struggles throughout the interwar years between the profession and the societies which produced different scenarios in each state, laying the basis for aspects of medical politics ever since. Some doctors were actually ready to accept increased state regulation in order to protect their incomes (Gillespie 1991; Sax 1984). Internal brawls within and between State branches of the British Medical Association (the *Australian* Medical Association only from 1962), however, as well as federal political vacillation, meant that attempts to introduce a national insurance scheme in the late 1930s did not eventuate (Gillespie 1991: ch. 4).

In carving out a 'market' for medical services, doctors sought the custom of birthing women which provided the basis for later family practice. Oriented primarily to protecting the economic stability of male breadwinners, the friendly societies had not offered coverage of maternity cases, with families paying privately according to their means for professional and domestic assistance. The most indigent, at least in the capital cities, also had access to the few public hospitals providing care for women (e.g. see McCalman 1998). In the early years of Federation, the Australian state lent important support to the extension of medical attendance at births and hence to the demise of traditional midwives. This was accomplished through legislation restricting midwives' practice and increasingly incorporating them within nursing. The process started with Tasmanian legislation in 1901, with other states following through to the late 1920s (Willis 1983: 115; Thame 1974: 170; Western Australian Branch of the National Midwives Association of Australia, 1984). As legislation was State based and affected by idiosyncratic political factors, there was no uniformity in regulatory patterns nor in the education of midwives – problems which have continued to inhibit a national approach to midwifery and maternity provision in Australia. Many midwives, with varying degrees of training and expertise, became registered with the new state boards established to control midwifery practice. These were dominated by medical interests, with newly emerging nursing organisations also seeking influence.

The Federal Government's Maternity Allowance or 'baby bonus', instituted in 1912, initiated some role for the Commonwealth with regard to maternity care, but primarily as a pronatalist population strategy. The £5 benefit was to be paid to mothers on the medically accredited birth of a live child, but to white women only. It was available however to single as well as unmarried mothers. The lively debates which resulted were more about its potential for encouraging 'immorality' than its racist underpinnings or support for medical supervision. Actually, doctors initially opposed it – preferring the payment to go directly to professional carers yet fearing midwives rather than doctors would benefit – but the measure apparently encouraged medical attendance at the birth (Reiger 1985: 89). The proportion of women attended by a doctor for childbirth rose nationally from 63 per cent in 1914 to 77 per cent in 1923, with rates in Victoria and South Australia generally higher (Morris 1925). The fundamental principle was established that women could be given a limited individual benefit but that, apart from the very poor, families were responsible for financing and arranging their own care.

Rivalry between doctors and midwives over market share continued over the next few decades. Traditional midwives, whose training and skill varied, were brought under the jurisdiction of new Midwives' Acts, and both their registration and training carried the explicit aim of accustoming them to medical supervision (Reiger 1985: 91). Midwives however, were challenged not only by medical practitioners but by the growing number and organisational strength of registered nurses (Reiger 1985: 92; on nursing politics see McCoppin & Gardner 1994). Midwives' fees were significantly less than those of doctors – £2.2–£4.4 for confinement and a week's care in 1913–14 compared with a doctor's £5 for attendance at the birth. These charges remained consistent throughout the interwar years (Thame 1974: 162).

While many women continued to give birth at home – probably about 40 per cent through the 1920s (Thame 1974: 171) – this period saw the growth of many small private hospitals as well as of a few large women's hospitals in metropolitan areas. Local 'cottage' or lying-in hospitals were often inadequately equipped but became popular as an alternative to birthing at home, providing continuity of midwifery care and some medical supervision. During the interwar period, as I have discussed in detail elsewhere (Reiger 1985), mothers came to share doctors' concerns about the health problems resulting from poor care and about high maternal mortality and morbidity rates. These were the subject of several inquiries with doctors themselves alarmed at practices of their colleagues. As Thame (1974) points out however, other, non-medical factors also encouraged the move away from home confinements, including improved transport to hospital care, a decline in domestic support and the building of comfortable private wings at public hospitals. The growth of large maternity hospitals provided a significant example in metropolitan areas, with some large institutions, especially in Melbourne and Sydney, establishing a high profile. While infant mortality had steadily declined, significant maternal mortality rates through to the 1930s, led to increased attention being paid to antenatal care. Women were encouraged to attend the first public antenatal clinics, but were generally reluctant to submit to increased surveillance (Reiger 1985: ch. 4).

Struggles continued over the status of the public hospitals – were they still to be largely charitable institutions or become publicly funded training bases for medical training? General practitioners were generally hostile to the development of maternity hospitals, seeing them as threat to their livelihood. The few specialist obstetricians whose professional visibility increased in the interwar years usually maintained a base in general practice. They became quite skilled at manipulative techniques and remained cautious of excessive surgical intervention in birth. They nonetheless sought improved facilities for medical training. Following British colleagues, they used positions as Honorary Consultants in public hospitals to expand their influence, and promoted the setting aside of beds for their private patients by WW2.

The scene was set, therefore, for the final demise of domiciliary confinement, the continued growth of the larger hospitals, an interlocked system of private and public health care and continued struggles over financing. The private sphere of medical practice was entrenched and midwifery became subsumed within the expanding

profession of nursing, lost in its internecine factional fights (McCoppin & Gardner 1994). No effort was made to establish widespread publicly supported midwifery services, such was the proclivity towards individual or family responsibility for health care. This was not only characteristic of the middle class, but fundamental to the friendly societies' provision for the working class and reflected in government policy. A strong public hospital sector, at least in main urban areas, set medical standards and provided the base for the growth of obstetricians' dominance of maternity care.

## HEALTH POLICY IN POSTWAR YEARS

Postwar reconstruction policies under the Labor party included extending health provision along with many other measures to establish a welfare state. The Commonwealth's financial role had expanded as it took over income taxation revenue in 1942, and the Labor government implemented many social security measures along with a national pharmaceutical benefits scheme. New hospital funding arrangements, established in 1945, laid the basis for agreements with the States for non-means-tested provision in public hospitals. As hospitals then found other funding sources declining, support for the scheme waned and only Queensland maintained free public hospital services after the return of a conservative Federal government in 1949. The other States 'settled for a subsidised entrepreneurial model, organised by the medical profession' (Crichton 1990: 40) thus maintaining the control of doctors over the hospital and medical system.

Labor's plans for a national medical service in 1948 had been vehemently opposed by doctors, who argued that a salaried service would introduce an unconstitutional form of 'civil conscription' and involve a third party – the state – in the private contractual arrangement between doctor and patient. Many attempts were made to adjust the proposed scheme to meet the doctors' demands for a fee-for-service basis which would ensure freedom of choice of doctor, but it was not implemented by the time Labor lost power in 1949. Australian doctors shared the resistance of British colleagues to increased state control and had the political power to block the initiative. Conservative political forces and the doctors played on the links with projected bank nationalisation, and fears of centralisation of power in Canberra. Concerns about 'socialised health' then took on new cogency in the emerging Cold War climate (Sax 1984: 58).

During the early 1950s, under the Menzies conservative government, a new system of voluntary health insurance was established to cover both medical and hospital benefits. It built on the expansion of the friendly societies into medical insurance organisations and new funds oriented more to a middle-class clientele (Crichton 1990: 43). Under the lead of the Minister for Health, Earle Page, a doctor sympathetic to the BMA position, the scheme consolidated medical power. During the following period of stability until the 1970s, the private sector health care expanded, underwritten by state support through tax benefits for private health insurance, along with direct provision of funding for capital works and hospital services. These funding arrangements remained institutionalised until the reformist Whitlam Labor government introduced a new form of non-means-tested medical and hospital insurance in 1975. As with earlier attempts to establish national

schemes, this struck major opposition from the medical profession (Sax 1984: 108–113). Significant changes were made to accommodate doctors' interests, but the fall of the Whitlam government in a political crisis in late 1975 meant the demise of Medibank under the incoming conservative Fraser government.

The popular appeal of national health insurance led to Medibank's reinstatement in significantly modified form as Medicare under the new Hawke Labor government in 1983. Implemented in 1984, Medicare relies on Commonwealth revenue raised through a compulsory tax levy and provides for distribution of funds to the states for provision of free public hospital services. It also underpins private medical care through direct reimbursement of some 85 per cent of consultation costs (for details see Crichton 1990: ch. 6; Duckett 2000: 36–8). Private health insurance has remained part of the system however. Although numbers insured steadily declined after the introduction of Medibank/Medicare, from 80 per cent to 30 per cent of the population between 1972 and 1999 (Duckett 2000: 39), they have recently been rising again in view of the current government's tax incentives and strong ideological pressure towards individual responsibility. Two-thirds of Australian health expenditure comes from government sources with Federal authorities responsible for 46 per cent and states and local government (mostly care for the elderly and public health) for 24 per cent. Consumers, health insurance and workers' compensation funds make up the remainder (Duckett 2000: 28). The debates on financing and control of health care provide an essential backdrop to understanding salient features of maternity service provision. Over recent decades, the public hospital system has lost much of its earlier stigma for women having babies, but the private sector has also expanded, both in terms of hospital provision and private obstetricians increasingly replacing GPs as medical attendants at birth.

**Maternity services and midwifery**

While doctors' accounts of the expansion of the medical management of birth stress professional advances in obstetric knowledge and technical procedures (Reiger 2001), the role played by other stakeholders has been crucial. At federal level, and at least in NSW (evidence from elsewhere is not yet available), by the 1960s government policy encouraged the use of private obstetricians through funding arrangements and facilitated their influence over state health policy (Schofield 1995: 144–5). Obstetricians had become increasingly organised as a specialty during the 1950s, forming their own Australian professional College. British ties remained strong, however, such as through postgraduate training. From the mid-1960s through the 1970s, obstetricians' power expanded within the hospital sector and their influence on government policy strengthened. The imposition of fees for public ward stays during the 1950s, save in Queensland, made 'voluntary ' insurance almost mandatory and encouraged women to seek private obstetric care in order to ensure some degree of continuity of care (Schofield 1995: 107). Schofield documents the process through which women's needs in childbirth were increasingly defined in 'specialist-therapeutic' terms. For example, as NSW Health Department discourse shifted from concerns with maternal mortality to perinatal mortality, medically controlled antenatal care from *specialists* was seen as the best preventative measure, and GPs were encouraged to accept their expertise concerning childbearing.

In spite of these developments, nurse-trained midwives continued to play an important part in public hospital birthing care, including in the training of the younger generation of doctors. No full history of midwifery in Australia is available though their role in cottage and larger hospitals has been described for NSW (New South Wales Midwives Association, 1984) and details of developments in most States have been compiled (Western Australian Branch of the National Midwives Association of Australia, 1984). Willis (1983) and Keleher (2000) provide analyses of their increasing regulation by the state and subordination to the interests of nursing, closely linked as this was to increasing nursing's own status. The rivalries between, and growing power of, nursing organisations have been discussed by others (e.g. Bessant & Bessant 1991; McCoppin & Gardner 1994). In these accounts, however, midwives remain largely invisible, their interests subsumed by nursing agendas, at least until midwives themselves sought new visibility in the late 1970s. Australia's centralised wage regulation and arbitration system enabled nurses' industrial claims to be visible, adding weight to the arguments of those nursing leaders who saw workplace concerns at more significant than more narrowly defined professional goals. In recent decades, the Australian Nursing Federation (ANF) has become a powerful organisation, with the Australian College of Midwives finding it difficult to attract members who also seek the legal and industrial protection offered by the ANF. Tensions between a quest for professional status and the pressing concerns of the hospital workplace continue (Reiger 2002).

Little analysis has been directed at the role of traditional, apprentice-trained or 'lay' midwives in late twentieth century Australia. While their presence at some homebirths continues, it was more commonly acknowledged during the growth period of the homebirth movement in the late 1970s. The professionalising project of nurse-trained midwives has constructed non-registered midwives as an undesirable 'other'. Hence, only when charges are laid against them for practising, such as a recent case in Queensland, is there even recognition that there is any sort of 'underground' practice occurring. It appears to be mostly concentrated in alternative communities in semi-rural areas, with little opportunities for genuine dialogue about the role of traditional birth assistants. Even with regard to the needs of indigenous and immigrant communities, the presence of 'lay' midwives is not widely acknowledged. There have been some moves at an informal level, by health professionals working with the Somali community in Melbourne for example, to recognise the expertise of traditional birth attendants in dealing with the management of birth after genital mutilation. However, allegiances formed with consumer groups and the collective political action such as that associated with the Midwives Alliance of North America (MANA) have not occurred in Australia.

The expertise of registered midwives in the postwar decades was based increasingly on their being a speciality of nursing with midwifery training largely taken as a second certificate for career reasons. Especially in the large metropolitan women's hospitals, some distinct midwifery identity remained, partly as the legacy of the earlier culture of direct entry programs but also reflecting the cohesion of the major women's hospital training programs. The resurgence of midwifery during the late 1970s, escalating in the 1980s, was linked to two separate developments. The move to tertiary training of nurses

and midwives increased their political consciousness, awareness of skills and assertiveness. A more critical attitude to medical power, including in the management of birth, resulted. The childbirth reform movement also heightened consumer expectations, and provided formal training for childbirth educators. The movement challenged midwives to return birth to a more family-friendly or even women-centred experience but, with notable exceptions, midwives found themselves lagging behind physiotherapists in doing so (Reiger 2001: ch. 8–9). By the later 1980s, they were emerging as a more self-conscious profession, seeking to some extent to work with consumer organisations, especially in homebirth, but also in establishing 'Alternative Birthing Centres'. Although a strong feminist health movement had emerged in the 1970s, achieving significant gains in terms of stated policy units and community-based services, it did not generally include maternity care in its brief. Rather it focused primarily on women's rights to fertility control and on work-related health concerns (see Broom 1991; Reiger 2001: 166).

In the late 1980s a combination of consumer pressure and sympathetic professional and political leadership generated policy moves which culminated in significant reviews of childbirth services in several states (e.g. Department of Health NSW 1989; Health Department Victoria 1990). The concerns in each were distinctive, reflecting particular local circumstances such as the geographical location of services, but there were also similar imperatives at work. In health departments generally, the beginnings of the recurrent organisational restructurings of the next decade were just being put in place, such as the establishment of Area Health Boards in NSW and the regionalisation of Victorian health administration. With Labor in power at the Federal level and in several states, notably Victoria and NSW, women's policy units had significant influence (Reiger 1999; Schofield 1995: ch. 6). As Schofield notes there was considerable debate about homebirth in the media, and women's health policy was being considered in several forums. The National Health and Medical Research Council revised guidelines on homebirth and there was growing attention to the importance of consumers in formulating health policy, such as through the formation of the Consumers' Health Forum in 1985. Some key female politicians provided a pressure point for lobbying by articulate maternity consumer groups, including homebirth groups.

The complexity of the politics and discursive processes associated with the NSW Shearman report has been discussed by Schofield (1995), and that of the Victorian Ministerial Review of Birthing Services by Reiger (1999). In Western Australia, a Ministerial Task Force was also established in 1988, reporting, like those in the Eastern states, two years later. In this case, the future of the major maternity hospital, the King Edward Memorial Hospital (KEMH), was a particular focus. It received a separate report from an independent consultant expressing misgivings about its management and loss of public confidence (Western Australia Ministerial Taskforce 1990). These concerns were never addressed and KEMH has recently (2000–01) been the subject of a major commission of inquiry. In South Australia the concerns were strongly administrative, and Tasmania and Queensland did not have comparable investigations.

In other States the inquiries entailed a very significant process of public consultation and debate. While obstetricians led most of them, in Victoria the role was given to a leading

epidemiologist, Dr Judith Lumley, who had already established a liberal position through her involvement in establishing a birth centre. The Victorian Report, *Having a Baby in Victoria*, was distinctive in its accessible style, but most of the Reviews provided space for dialogue about the management of birth and many positions were articulated (Schofield 1995; Reiger 1999). Women as 'consumers' of maternity care emerged as a new discursive entity (Schofield 1995: 209–13) along with 'special needs groups' such as non-English speaking women. It is not possible here to provide detailed comparative analysis of these reviews, but their reception and implementation, or lack thereof, is germane to the purposes of this paper.

Although they reiterated a strong commitment to pulling back from the increased intervention in childbirth, medical concerns with safety remained to the forefront. Hence the report on 'Obstetric and Neonatal services in South Australia' proclaimed contradictory message. On the one hand 'childbirth is a natural process which, in the majority of cases, does not need medical intervention', but in the following sentence, it equated birth with the 'delivery of obstetric care' (SA Health Commission 1987: 3). The various Reviews reiterated common themes – that as birth is not an illness, contemporary hospitals have to become more 'family-friendly', and that services have to be more equitably located and sensitively delivered. Thus far, so good. However, the power relations already embedded in the management of birth, and the structural arrangements of the existing health system were, not surprisingly, not open to question. Although submissions certainly raised more radical positions, the resulting Reports were constrained by the requirement of cost neutrality and by organisational realities.

In NSW there seemed considerable commitment to implementing both the recommendations on relocating services to meet community demand and to trialling new models of care. An Implementation report released in 1993 (NSW Health Department, 1991) reported the positive reception of the Shearman Report and measures to establish five-year plans in each Health Service Area. Resistance to change was not acknowledged; however, other research indicates that new systems can encounter significant hostility and developments such as team midwifery have to be managed carefully (Brodie 1996). In Victoria, the recommendations were left to languish in the bureaucracy when key people departed and there was little political momentum to drive change. While particular maternity services adopted some recommendations of the various reviews, there was no effective monitoring system put in place and no national maternity policy coordination.

These important policy developments were overtaken by the early 1990s by the swing to the political right which replaced the motivation for changes oriented to increasing equity and consultation with those focused on efficient outcomes and efficiency. Corporate managerialism and restructuring of the public sector in the light of a market ideology was more pronounced in some states, such as Victoria under the Kennett government, than in others, but the policy environment which had seemed so conducive to modifying technological dominance of childbirth had dissipated. The National Women's Health Policy at the Federal level provided the framework for an 'Alternative Birthing Services Program' which funded a variety of innovative projects during the 1990s, but many eventually collapsed as funding of pilot projects was not replaced by recurrent funds. The

consumer groups which had been active in the 1980s were running low on energy by the mid-1990s, unable to sustain the necessary momentum to push for effective implementation of the various inquiries' recommended changes (Reiger 2001: ch. 11) . At local levels, various hospital managements certainly took up alternative care models, introducing shared care between GPs and obstetricians and some midwifery models, but there was no major systemic change.

All the while intervention rates continued to increase – C-sections rising from around 18 per cent at the start of the decade to some 25 per cent by its end, with many large private hospitals having considerably higher rates especially for first births. The public/private provision of hospital care became further entrenched with expansion of large corporations into the health services market. Some public hospitals, but also some private, emerged as centres of innovation and maternity care became more varied than in earlier decades. Managements became preoccupied with economic issues in view of state-initiated cost cutting and the administrative restructuring of local and regional networks. The contemporary policy and service delivery environment, therefore, is shaped by many factors. These include the structural context – complex funding arrangements, private and public service provision and the location of the majority of birthing services in acute hospital settings in which medical power remains often unquestioned. The historical and recent tensions in professional relationships between medical practitioners and nurses/midwives are now joined by differences of orientation within the midwifery profession itself (Reiger 2000; Lane 2002). Further factors reflect changes in the nature of the operation of the state during the 1990s and it is to discussion of current issues in changing maternity care that I now turn.

## CONTEMPORARY POLICY ISSUES IN AUSTRALIAN MATERNITY SERVICES

The advent of neoliberal health policy during the 1990s in Australia and the imposition of a market model on health service provision has occasioned much debate (see Hancock, 1999; Duckett, 2000). The implications for maternity care however, have not been critically assessed on a national basis. To gain some understanding of differences and similarities in maternity policy across States and territories since 2000, key policy documents and web sites were reviewed and various policy advisors were contacted by telephone to ascertain local administrative arrangements for maternity care and recent developments. This data-gathering strategy has not provided the basis for a comprehensive and detailed picture, nor is there space to develop it here. Yet several recurrent themes can be discerned, particularly around organisational frameworks, innovation and service provision, and management of professional relationships and consumer involvement .

Health policy advisors found it difficult to comment on long-term patterns of change in maternity care because of ongoing reorganisation with subsequent staff upheaval and insecurity. Most reported that it was difficult to provide a current organisational map of maternity service policy-making as it was never up to date. This reflects the instability of administrative restructuring at regional, State and Federal levels which new public sector management strategies have produced (Grant & Lapsley, 1992; Duckett, 2000). Several

major restructures in Health Departments have meant constant shifting of people and high levels of stress. The problem also involves loss of institutional memory, including through the increased use of external consultants. In Western Australia for example, the Health Department has had no maternity policy section, only recently introducing a new structure with a Maternal and Child Health Division.

The structural location of maternity services within the dominant hospital sector means fragmentation of policy concerning community services, especially post-natal care. On the one hand effort in developing materials, such as for consumer information, can be duplicated even within a State (Keleher et al. 2002), and also across States, such as with hand-held maternity records. On the other hand, information about developments elsewhere, including on maternity records, may not be widely shared at all. In Queensland, it appears that there is little state-wide policy at all, with decisions being implemented at the regional or zone level, and even being merely 'facility-based'. While this can allow innovation, it also allows great disparity between services and possible inequity for childbearing women. Problems of service location have been contentious, and continue to be in NSW, but regional/network administrative arrangements seem now to be relatively stable. However the lack of national planning in maternity services, reflecting the historical patterns of State responsibility for health service delivery, continues to hinder reform of maternity care. It is common to find that information dissemination across state and even regional borders varies enormously within States, often according to professional and personal networks, but also shaped by the political complexion of governments holding power in each State/Territory.

The most significant Federal initiative of the late 1990s, the Senate inquiry into intervention in childbirth (Senate Community Affairs References Committee 1999) was also affected by party politics. During an intense period of nation-wide hearings, it undertook important consultative work, and the Report provides a valuable analysis of factors affecting increased intervention patterns. However, chaired by Labor Senator Rosemary Crowley, the conservative Liberal government found it politically unpalatable, preferring to leave it 'on the shelf'. Nonetheless, political climates change, and with the return of Labor administrations in most States, earlier Reviews of maternity service provision have been able to provide a basis for new initiatives and strategies. In Victoria, for example, the Maternity Services Enhancement Strategy, initiated by the Liberal Government as a part of a women's health policy development, was adopted and revamped as the Maternity Services Program under the incoming Labor government in late 1999. It continues to provide support for a range of programs, the groundwork for which had been laid by the 1990 *Having a Baby* Report supported by a previous Labor administration (Health Department Victoria 1990).

Australian maternity services in recent decades have struggled to develop innovative models of care. Meeting the needs of an increasingly culturally diverse population and delivering services to a diminishing population in rural and remote areas challenge each State/territory administration. For example the important policy document, *The NSW Framework for Maternity Services, 2000 –1* (NSW Health Department 2000) stresses the diversity of needs and the Victorian Maternity Services Program has funded several

innovative projects for Indigenous and immigrant women (Keleher et al. 2002). Most health policy advisors noted that it was important to increase the birthing options of a wider range of women than has been achieved to date. In Tasmania, for example, recent consultations for a review of maternity care showed that the needs of Aboriginal and women from culturally and linguistically diverse cultures were under-represented in policy and workforce planning. More midwifery, holistic, continuity of care/carer models were being planned for all women, not just those in urban areas. The complex health situation of Aboriginal mothers, including problems of drug and alcohol dependence, and of low birth weight babies is widely recognised. Some important initiatives are now in place but major problems persist, especially in remote areas.

In the Northern Territory, Western Australia and Northern Queensland, policies of routine transfer to hospital for birth lead Indigenous women to avoid antenatal care for fear of dislocation. Staff shortages are everywhere but especially difficult in remote areas, which can attract short-term staff from the southern states but find them hard to keep. Ironically, however, in the NT, there seems to be more effective continuity in the *management* of care for Indigenous mothers in outlying centres such as Katherine than for those in Darwin. As well as the hand-held record card in use since 1997, care is taken to ensure hand-over of information to mitigate the transfer problems. In Darwin, Aboriginal women are seen antenatally and postnatally by local community health workers, but there is little hand-over to the hospital where birth takes place. Although many issues are particular to disparate geographical areas, increased flow of information through something like a federally- supported national clearing house on maternity issues would support hard pressed policy advisors, many of whom lack in-house knowledge as a result of organisational restructuring. Other issues facing policy-makers include the collection of effective information and improving consumer participation in service planning.

Established systems of perinatal data collection are being further improved in several States and Territories. Victoria, like NSW, is moving to making information about intervention patterns at all hospitals available to the public. Policy in the Northern Territory is placing increased focus on antenatal care, developing guidelines for managing sexually transmitted health problems and those associated with smoking and alcohol. In South Australia, working groups on neo-natal /perinatal care, on models of care, and on gynaecology/reproductive health, have been developed since 2000 in order to implement the ‘Healthy Start’ review of clinical service provision. South Australia has been a strong leader in attempting to involve maternity service users in their care. Mother-held maternity records have been used since 1997–98, and new consumer information pamphlets have been developed with strong consumer input, but this process and outcomes continues to be contentious. Few States, however, have effective policies for including consumer participation at varying levels of policy making. Queensland Health is examining several program areas: issues include consumer participation and questions of informed consent as well as implementing clinical audits.

New attention to using standard clinical indicators has arisen from the most significant recent inquiry into maternity care in Australia, that into the King Edward Memorial

Hospital (KEMH) in Perth (WA Health Department 2001). Consideration of the implications of the KEMH Inquiry goes beyond the scope of this paper, but it has exposed in a stark way the historically embedded problems of medical dominance. As noted earlier, Western Australia, like most other States had held investigations into maternity services in the early 1990s and a more recent review was conducted in 1995 (Western Australian Legislative Assembly 1995). However, a highly political process unfolded during the 1990s as several women launched formal complaints against the major tertiary hospital, KEMH, for 'adverse outcomes' in which their babies had died or their health been compromised. KEMH insisted that its standards accorded with 'world's best practice' but that it was also unique in being the only tertiary centre for a large State, dealing therefore with many complex health problems. Problems had already been recognised though. Both an independent consultant's report in the late 1980s had raised concerns, and a further report by a midwife and an obstetrician pointed to major problems in the culture of clinical practice and management strategies at KEMH. A major investigation costing some $7 million, and taking two years, has now reported on many systemic problems: these relate to inadequate accountability of senior medical staff for junior colleagues, ineffective complaints mechanisms, and an apparent culture of hiding problems. The politics of this Inquiry require further explication but the extreme confidentiality restrictions imposed on investigators are bizarre to say the least. Even the 'common clinical errors' found remain hidden from public and wider professional gaze, and case material which can potentially throw light on the processes at work has not yet been released in spite of it being de-identified. Many of the problems unearthed at KEMH reflect the historical nature of maternity service delivery in Australia more widely, especially the power of doctors, often aided by politicians, to set and control the agenda.

**Conclusions**

This paper has reviewed the development of maternity services in Australia, indicating the processes shaping the current organisation of care of childbearing women. The basic parameters were established in the first half of the twentieth century and into the post war years. These included the entrenched nature of medical influence on health policy, and the fragmentation caused by Federal–State division of responsibilities. Maternity provision became locked into acute health, with both public and private sectors primarily offering an obstetric, illness-oriented model of care. Although the recommendations of the reviews of maternity services carried out in the late 1980s–90s were not especially radical, they were largely either ignored or implemented in *ad hoc* ways. By the 1990s, in spite of many valuable new initiatives to meet the needs presented by a heterogeneous population and stronger consumer voice, fundamental systemic change was not on the agenda.

In hospitals, midwives continue to struggle to assert their professional role as autonomous carers of childbearing women, an enterprise largely undermined by the relentless rise in surgical and other interventions and by stretched resources. A staffing crisis looms not only in midwifery but in obstetrics, where it is exacerbated by rising professional indemnity costs. Homebirth remains an expensive option available to very few women, with accessibility further worsened since 2001 by the withdrawal of

professional insurance for independently practising midwives. The development of a National Maternity Action Plan in 2001–02 by consumer organisations promotes community midwifery models of care (Maternity Coalition et al. 2002) but would require a major shift of professional and political thinking to implement. In view of staffing and funding crises, however, time seems ripe for a more far-reaching overhaul of maternity services than achieved to date.

The mix of change and continuity in Australian maternity care reflects the nature of the health system but also the struggles of professional groups and informed consumers. Formulating effective change strategies requires an understanding of historical and structural barriers to change. Those seeking to increase continuity of care and widen women's options regardless of insurance or risk status, and to decrease inappropriate medical interventions, also have a legacy of struggle upon which to draw. Previous investigations of the limitations of maternity provision in Australia remain a valuable resource and the fragmented nature of State-based policy processes can be used to argue for local initiatives on the basis of developments elsewhere. Nonetheless, even incremental change continues to be 'difficult labour'.

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## THE AMAP MIDWIFERY EDUCATION SURVEY

**Leap N, Sheehan A, Barclay L, Tracy S & Brodie P Mapping Midwifery Education in Australia: Full Findings of the AMAP Education Survey, July 2002**

### INTRODUCTION

In 2001, researchers at the Centre for Family Health and Midwifery, University of Technology, Sydney undertook a survey of midwifery education as part of the Australian Midwifery Action Project (AMAP).[1] The aim of this study was to describe the current position of midwifery education across Australia, as identified by the midwifery course coordinators in each university offering a program for initial authorisation to practise midwifery. This study compared courses[2] on a range of issues including course demographics, prerequisites, and arrangements for theoretical and clinical practice components.

This compilation provides AMAP industry partners with some contextual description plus a full set of data. To follow are two brief papers, the first a more succinct version of Section 1 of this document, with the second exploring the barriers and strategies to effective midwifery education as described by the midwifery course coordinators and outlined in Section 2. As the data was generated almost entirely in interview and discussion around the survey questions, we have included the richness of experience and opinions offered by the midwifery course coordinators with a selection of representative qualitative description.

### BACKGROUND

The quality, nature or process of education of midwives has not been seriously studied in Australia for nearly two decades. During this period, programs have moved from hospital locations and teaching to universities. The hospital programs and their regulating framework of the 70s and 80s were recognised as highly problematic (Barclay 1986) but, despite this, recent major shifts in education have not been managed, monitored or evaluated.

Since Barclay's 1986 thesis, concerns regarding inconsistencies across states and territories and barriers to appropriate midwifery education and regulation have continued to dominate discussions (Hancock 1992, Barclay 1995, Barclay & Jones 1996, Barclay 1998, Bogossian 1998, Waldenstrom 1996, 1997, Leap 1999, Glover 1999a, 199b, ACMI Victoria 1999, Tracy et al 2000, Brodie & Barclay 2001, Leap & Barclay 2002). Recent studies of midwifery in Australia, undertaken by the Australian Midwifery Action Project (AMAP 2002), suggest that there is a crisis of confidence in the education and monitoring of the maternity workforce. Also, across Australia, there are concerns about the fact that there is no national planning, monitoring, regulation or quality control of midwifery education.

These factors are particularly significant given that, in the last decade, new models of maternity care have been developed in Australia and overseas in response to changes in government policies and the identification of strategies to better meet the needs of childbearing women (Tracy et al 2000, NHMRC 1999). According to Page (1997:5), 'the basis of these reforms in all countries is the provision of appropriate education and preparation for modern day midwifery practice'. In Australia, as elsewhere, midwives are licensed so they must be prepared at a level that enables them to function as practitioners in their own right on graduation, without having to undertake further education or training. This means that graduates of midwifery education programs should be capable of taking responsibility for the total care of a woman (and her baby) throughout the woman's pregnancy, labour and birth, and the early postnatal period, referring to other health professionals only when complications arise.

The introduction of innovative maternity services has contributed to changes in the way midwives are educated overseas. In New Zealand, Canada, the United Kingdom and other European countries, the dominant form of preparation for practice is through three and four-year courses rather than routes

[1] The Australian Midwifery Action Project (AMAP) was funded by the Australian Commonwealth Government through the Australian Research Council as part of the then 'Strategic Partnerships with Industry research and Training' (SPIRT) program. A three-year project, AMAP was set up in April 1999 to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia and strategies to address these barriers. This included studying workforce, regulation, education, practice and service delivery issues across the country.

[2] In terms of nomenclature, and in the interest of clarity and consistency, midwifery education programs are generally referred to as 'courses' throughout this paper since this was identified as the most common terminology in use when designing the questionnaire and during the telephone interviews.

that require students to be nurses first. There is a move towards nurses having to undertake at least two years of full time study in these three and four year programs in order to qualify as midwives and function as practitioners in their own right.

While Australia had its own 'direct entry' course until the 1960s, according to anecdote this was a less than adequate one year program (Barclay 1986). Since then, all midwifery education in Australia has been through postgraduate nursing courses. However, in 2002, over 130 students commenced study in a three-year Bachelor of Midwifery in four universities in South Australia and Victoria. At least four other universities in New South Wales, ACT and Victoria are planning to start a three-year Bachelor of Midwifery (BMid) in 2003. It is clearly urgent to review what is happening in existing courses to assess the impact of university education so that the implications of a dual route of preparation for midwifery practice may be better understood.

Researchers at the Centre for Family Health and Midwifery (CFHM), University of Technology, Sydney (UTS) were recently commissioned by the Department of Education, Science and Training (DEST) to carry out a review of Australian midwifery education. This extensive review explores issues facing midwifery education in Australia within an international context and can be found on the DEST website (Leap & Barclay 2002)[3]. It complements and informs the empirical work reported here undertaken by AMAP by providing an international analysis that it was not possible to undertake within the remit of AMAP. The DEST review highlights serious concerns about the standard of midwifery education in Australia, with inconsistencies across states and territories, a lack of professional leadership and an absence of high quality accountability structures for courses (Leap & Barclay 2002).

## METHODOLOGY

This study was undertaken on behalf of AMAP by three researchers with different roles. Researcher A (NL) oversaw the study in consultation with the AMAP Chief Investigator (LB). Researcher B (AS) conducted the interviews, collated and coded the data from the questionnaires, and presented it in a blended, de-identified format to NL and LB for analysis.

Using a structured questionnaire and undertaken primarily using telephone interviews, a survey was administered of universities offering a midwifery course leading to authorisation to practise as a midwife. Questions were answered by midwifery course coordinators, many of whom entered into discussion and shared additional information that has been reported as qualitative data when this contributes to understanding.

Ethics approval was given for the study in October 2000. The study commenced in May 2001 and data collection was completed in February 2002. We have presented this descriptive data using summaries, quotes or simple frequencies in the case of numerical data being most relevant.

The questionnaire was designed by Researchers A and B, reviewed by other AMAP researchers and two midwifery course coordinators (from different states) who also piloted the survey to identify any problems with the questionnaire. Experienced managers of maternity services and other AMAP industry partners made further comment through the AMAP meetings. Other AMAP researchers assisted in refining the survey tool, which was adjusted to take account of all recommendations and perceived omissions and strengthened through this process.

The Australian Vice Chancellors Council (AVCC) web page listing all universities in Australia was accessed to identify which universities conducted midwifery programs. Researcher B used this process to identify which universities had midwifery programs. Thirty universities were telephoned to confirm that the university had a midwifery program that led to authorisation to practise as a midwife, as well as to identify the course coordinators and gain contact details. Ultimately only 27 of these universities were identified as offering midwifery courses *leading to authorisation to practise as a midwife*. Twenty-six courses in 19 universities were excluded from this study as they were identified as postgraduate courses for *registered* midwives.

A letter and the questionnaire were sent in late May 2001 to all the identified midwifery course coordinators, informing them of the research and asking them if they would like to participate in the study. They were assured of confidentiality and anonymity and were informed that the researcher carrying out the survey (AS) would de-identify the data before it was provided to the researchers analysing the data (NL and LB). A number of iterations were necessary between research team members to preserve confidentiality as we fully interrogated the data.

[3] http://www.dest.gov.au/highered/nursing/pubs/midwifery/1.htm

Researcher B telephoned the coordinators to seek consent and to make a time for the interview to be undertaken. All course coordinators gave consent to participate in the study. Four participants chose to complete the questionnaire and return it by mail rather than engage in a telephone interview. These participants agreed to be telephoned if there was a need to clarify any of the answers.

The data was collated and coded by Researcher B who then presented it in a blended and de-identified form to Researchers A and C for analysis to:

describe the nature of midwifery education programs in Australia in terms of level of award, length of course, theory and practice components, assessment for initial registration, workforce data and issues

elicit information regarding the midwifery education course coordinators' views on the most pertinent issues affecting contemporary midwifery education in Australia. (In line with other research carried out by the AMAP team, participants were asked to identify barriers to midwifery education and strategies to overcome these barriers.)

**Additional information**

Additional information, commissioned by the Commonwealth Review of Nursing Education also informed this study (Leap & Barclay 2002)[4]. This included a comprehensive literature search on midwifery education in Australia, the United Kingdom (UK), Canada, New Zealand, the Netherlands and the United States of America (USA) and an analysis of the development of the three year Australian Bachelor of Midwifery. Databases, policy documents, research and other resources were studied, in collaboration and with assistance from national and international experts.

**FINDINGS: Section 1**

Twenty-seven universities across Australia were identified as having a midwifery course leading to authorisation to practise as a midwife. All twenty-seven participated. Data regarding both the double-degree (Nursing/Midwifery) course that commenced in one university in 2001 and the three-year Bachelor of Midwifery courses commencing in 2002 are not included in this survey. Thus data and findings only reflect courses for qualified nurses wishing to become midwives that were conducted during the sampling period of May 2001 – December 2001.

**Name of course and qualification on completion**

There were five different awards and titles given to the midwifery courses that lead to initial authorisation to practise as a midwife. One of the courses indicated it had two exit points, one at Graduate Diploma level and one at Masters level.

| Table 1. Australian midwifery courses leading to initial authorisation to practise as a midwife |
|---|
| Graduate Diploma of Midwifery [17] |
| Postgraduate Diploma in Midwifery [5] |
| Bachelor of Midwifery [2] |
| Master of Midwifery [2] |
| Master of Science (Midwifery) [1] |

**Entry requirements/prerequisites for course**

All 27 courses required that entrants have a registered nurse (RN) qualification and most required some experience in nursing practice and/or a current practising certificate in nursing. The nursing experience required varied considerably from university to university and included: RN qualification only [5], RN with at least 12 months recent experience of acute care nursing [3], RN with 'relevant' nursing experience (2), Bachelor of Nursing with a mechanism for assessing eligibility if no BN [3]. One respondent stated that, although it was not a requirement of the university per se, some hospitals

[4] http://www.dest.gov.au/highered/nursing/pubs/midwifery/1.htm

they use for clinical practice placements specify that students must have had at least one year of postgraduate nursing experience. One university would take candidates immediately following completion of a Bachelor of Nursing if they had worked as an Enrolled Nurse before obtaining a Bachelor of Nursing (BN) degree; otherwise this university required a minimum of 12 months of nursing, preferably in an acute setting. All the courses awarding a Masters degree stated that an undergraduate degree in nursing was necessary. However, one Masters course would consider candidates without an undergraduate degree in light of their previous 'life long learning'. This university recommended that students without a tertiary qualification should complete a graduate certificate before applying.

### Mode of Study

A variety of modes of study were identified with the majority of courses [16] running internally although seven universities offered an external mode of study. Four other universities offered both modes of study. One respondent stated that while their course was identified as internal by university classification, flexible arrangements were made because some students lived far from the university campus. In this situation, some study days on campus were supplemented by video conferencing as well as linking through email. Flexible delivery methods identified for external study modes included residential schools, paper distance learning packages by post, video conferencing and Internet links such as email, Internet talk lines, and interactive CD ROMs. Six universities offer only part-time midwifery education courses, two offer only full time study and the rest offer both full time and part time study modes.

### Course Costs

Approximately half of the participants were unsure about actual course costs. What could be identified however was that 20 courses were covered by the Higher Award Education Contribution Scheme (HECS), five were fee paying only, and two operated with a combination of fee paying and HECS liability.

## COURSE DEMOGRAPHICS

### Overseas students

Eight of the respondents identified that they had full-time overseas students in their courses with a total of nine overseas students enrolled.

### Age range of students

Not all respondents were able to identify the age range of students and generally the answers given were approximations. The majority of students fell within the 21-29 year age group. This was relatively consistent in all universities. Four universities had a larger percentage of students in the 30-39 year age range and another had an even distribution of students with 50% in the 21-29 year age range and 50% in the 30-39 year age range. Overall, approximately 40 students were identified as being within the 40 year + age group.

### Male students

Eleven male students were enrolled as of April 2001 although one had since withdrawn.

### Aboriginal and Torres Strait Islander students

It must be recognized that not all students who are of Aboriginal and Torres Strait Islander descent necessarily identify themselves as such and therefore the nine identified by midwifery course directors in this study may have been an underestimation.

### Total number of students

Respondents were asked how many students were enrolled as of April 2001. Their responses are summarised in the table below. One respondent did not know how many students were enrolled. She

estimated the number to be 18 but was unable to get conformation from the university administration[5]. These estimated 18 students have been identified separately. Twenty students who were not identified as full time or part time by another course coordinator have been counted as part time since the number of potential places was cited as 24 part time equivalent. Two course coordinators only gave numbers (18 FT and 32PT respectively) for one of the two cohorts offered at their university, one stating that she did not know the numbers for the most recent intake. Five other respondents identified that they run two cohorts per year and gave current enrolment numbers for both of these.

Table 2. Summary of current enrolments (potential places estimated as 693)

| | |
|---|---|
| Number of full time students enrolled: | 375 |
| Number of part time students enrolled: | 563 |
| (Counted as 281 FTE for university funding purposes) | |
| Total number of students enrolled | 938 (FT + PT)* |
| Total number of FTE enrolments | 656 (375 + 281 FTE)* |

* [+ estimated 18 FT or PT students and 2 unidentified cohorts of approximately 18 FT and 32 PT respectively]

**Projected annual numbers of graduates based on current enrolments**

Estimations of projected annual numbers of graduates *based on current enrolments* is problematic given the large number of enrolled part-time students (563), who take several years to complete their studies in some cases. This may lead to a significant over-estimation of numbers graduating each year. Although the total number of enrolled students was identified as 938, if the total number of currently enrolled part-time students (563) is halved and added to the total number of currently enrolled full-time students (375) one arrives at a total figure of 656. This calculation presumes that part-time students will complete in two years, which is not the case for many of these students who may take longer. This method of calculating projected numbers of graduates based on current enrolments should therefore be treated with caution since it may lead to over estimation.

**Potential places in courses**

Respondents gave a range of potential places from a minimum base of 10. The course that stated they had 10 student places was however currently over enrolled. The number of potential places on courses was difficult to evaluate, four participants saying that they could not give a number because they were 'limited by clinical placements' and one stating that 'it is open'. Nine of those who did give a number of potential places in their courses also stated that this varied according to the availability of clinical practice placements. There was confusion about potential and actual places since two part time students can count as one full time place in terms of funding. Approximately three-quarters of respondents however reported under enrollment on courses and at least two course coordinators stated that their numbers were decreasing. The total number of potential places identified added up to 693 FTE (allowing for the fact that 21 courses had full time and part time students, one had only full time students and three had only part time students).

[5] The researcher was unable to clarify this information despite several telephone calls and the genuine wish of the course coordinator to elicit the information. The difficulty was explained in terms of not knowing how many part time students, who take several years to complete, were in the course. The administration department eventually informed the course coordinator that the information could only be obtained by the researcher applying for special permission from the University Registrar. A decision was taken by the researcher not to proceed further.

**Approximate attrition rates from courses**

Three of the course coordinators described new courses that had not previously graduated students so this question was irrelevant in their situation. The total number of graduates from the most recently completed courses was 550. Five respondents stated that their attrition rate from the most recent course was 0%. The others reported an attrition rate that ranged from 0.06% to 30%. [Some of the answers to this were approximations]. One respondent stated that they only lost one student approximately every two years and another pointed out that the attrition rate in their course was from part-time students only and not related to full-time students. Crude calculations based on the number of graduates and estimated attrition rates suggest that approximately 65 students left the most recent courses before completion.

**Table 3. Estimated attrition rates in midwifery education programs**

| Attrition rate | 0 | 0-5% | 5-10% | 10-15% | 15-20% | 20-30% |
|---|---|---|---|---|---|---|
| Courses | 5 | 8 | 3 | 1 | 6 | 1 |

**Employment profile in midwifery of graduates from courses**

The course coordinators were asked to identify, from their own knowledge, the employment patterns of graduates. We acknowledge that this is a crude surrogate measure only. It appears from this source that the majority of graduates sought employment in midwifery but course coordinators believed that a concerning number ended up not being employed in midwifery. The total number of graduates identified by course coordinators as having gained employment in midwifery was 346 plus 20, 'most of whom' gained employment in midwifery. The total number identified graduating from courses not having gained midwifery employment was 114.

According to one respondent, some of those who were unable to find permanent employment in midwifery may have gained 'casual work' in the field. One course coordinator stated that she had 'no idea' as to whether the 57 graduates from the course sought or obtained employment. The same applied to other course coordinators in relation to 14, 11, and 10 graduates. The total number of graduates for whom their assumed employment status in midwifery was therefore not known was 92.

| **Table 4. Summary of graduate employment profile** |
|---|
| Total number of graduates from last course = **572** |
| Majority of graduates sought employment in midwifery |
| Number of graduates estimated to have gained employment in midwifery = **346** |
| (+ 20 'most' of whom gained employment in midwifery) **Total: 366** |
| Total number estimated to have not gained midwifery employment: **114**<br>(some may have 'casual work') |
| Graduates for whom employment status in midwifery not known: **92.** |

**Workforce calculations**

Depending on how projections are made for these 92 unknowns [366 plus or minus 92/572], attrition rates of new graduates can be estimated to range from 28% - 37%.

If these attrition rates of new graduates are applied to the 92 graduates whose midwifery employment status is unknown, an estimated potential 58 - 74 more midwives may have gained employment in midwifery. [366 + 58 = 424, 366 + 74 = 440] If all 92 graduates of unknown employment status in midwifery were to have gained successful employment, this would give an absolute maximum number of 458 [366 + 92] employed in midwifery out of 572 graduates. This number is likely to be an overestimation.

In terms of workforce planning, it is worth noting that the total number of students enrolled in the 3 new courses from which students have not graduated was identified as 39 FT and 22 PT students (50 FTE). However, these numbers should be viewed with caution, taking into account the concerning

large numbers of graduates who did not obtain employment in midwifery on graduating from the courses surveyed.

**Course coordinators who identified that there were no difficulties obtaining employment in midwifery for new graduates**

There were 10 respondents who identified that all, or almost all, of their students both sought and obtained employment. However, concerns were raised by some about insufficient new graduate programs and the lack of support available for new graduates. In some cases, graduates had to wait a while before being offered permanent full time positions. Two respondents identified that there were no difficulties obtaining positions for new graduates but they did not comment on the relatively low number of graduates from their programs seeking and obtaining employment in midwifery. (See Summary Table 5).

**Table 5. Summary of Course Coordinators who offered their perceptions of successful graduate employment rates and reasons for these**

| Sought employment | Obtained employment | Difficulty obtaining employment | Explanation provided |
|---|---|---|---|
| 100% | 100% | no | |
| 100% | 100% | no | |
| 100% | 100% | no | |
| 100% approx. | 100% approx. | no | Sometimes positions not open at time of graduation. They may need to wait 2 months or so. |
| 100% | 100% | | 3 were P/T positions and not all got into a graduate year program. In fact a lot knew they had been accepted prior to completing course. |
| 99.9% | 100% | no | |
| 99% | 98% | no | Pregnancy affected employment |
| 95% | 100% | no | No difficulty because of the shortage of midwives |
| 90% | 100% of these | no | No difficulties due to shortage of midwives, but lack of support for new midwives. |
| majority | most | no | Lack of availability of permanent full time employment |
| 75% | ¾ of 75% | no | Hospitals are keen to employ them. |
| 85% | 55% | no | No difficulties that I am aware of at the moment. |

**Course coordinators who identified that there were difficulties obtaining employment in midwifery for new graduates**

Eight respondents identified insufficient employment opportunities for graduates. One course coordinator highlighted a situation where graduates were not seeking employment in a particular hospital due to religious objections to abortion. Another identified that in some regional areas, employers insist on five years of experience in midwifery before they will employ midwives. The general consensus was that, where graduates are unable to obtain employment, some respond by working casually or for agencies, others move to another state or country to pursue employment in midwifery and some return to nursing. Figures were not available from one program concerning the large numbers of graduates from this course who experienced difficulty in gaining full time

employment in midwifery. Figures demonstrating the numbers of graduates who were unsuccessful in gaining employment in midwifery, with explanations when we were able to elicit them, are demonstrated in Summary Table 6.

**Table 6. Course coordinators who offered their perceptions of non-employment rates of new graduates and the reasons for these**

| Sought employment | Obtained employment | Difficulty obtaining employment | Explanation provided |
|---|---|---|---|
| 100% | 9.5% | yes | No midwifery positions available for new graduates. Some have casual work as midwives, one went overseas for employment in midwifery |
| 90% | 60-70% | yes | Insufficient employment opportunities for all graduates – some sought employment interstate |
| 80 – 90% | 70% of these | yes | In our area not many vacancies at the moment so a lot need to go on casual. |
| Approx. 80% | Approx.70% | yes | Some have voiced their inability to get post grad midwifery positions because their hospital doesn't offer midwifery. |
| 100% | 50% | | Religious objections to working where abortions are done. Students are received well because the university provides a good product. Problem with availability of jobs. |
| unanswered | unanswered | yes | They can get P/T and casual work but not F/T employment |
| 98% | 80% | yes | Because of the limited graduate midwife programs. All rural students have been employed post grad. The unemployed join agencies but many end up nursing. |
| 100% | 90% (1 chose to go elsewhere) | yes | In the regional areas the employers insist they have 5 years post grad experience in midwifery |

**Midwifery Courses offered for qualified midwives**

Eight universities only offered a course for initial authorisation to practise midwifery. Table 7 demonstrates the range of postgraduate courses for qualified midwives offered by the other 19 universities

**Table 7. Midwifery courses for qualified midwives offered by Universities** (n = 19)

| |
|---|
| Master of Midwifery [17] |
| Professional Doctorate in Midwifery [1] |
| Bachelor of Midwifery for qualified midwives [2] |
| Graduate Certificate in Midwifery Continuity of Care [1] |
| Graduate Certificate in Risk Associated Pregnancy [1] |
| Graduate Certificate in Independent Practice [1] |
| Midwifery Re-entry Programmes [2] |
| Postgraduate Rural Midwifery program [1] |

It is important to differentiate these 26 postgraduate courses for qualified midwives from the 27 courses for initial authorisation to practise midwifery. This differentiation has not been made by some authorities attempting to identify workforce projections.[6]

## PROGRAM DETAILS

### Subject Details

The subject outlines for each course varied considerably in the use of language and nomenclature. The subject titles described the areas of learning that might be expected in courses leading to authorisation to practise midwifery in the Australian context. The language used in subject nomenclature often suggested however a wide range of educational and midwifery approaches in terms of teaching and learning methods, style, philosophy, and ideology, particularly regarding the role of the midwife.

### Length of Course

Course coordinators were asked to describe the length of their courses based on full time study. This was problematic for the six who only offered part time courses; some of these gave estimates based on full time study, others gave the actual length of their part time courses. The length of courses for all those who offered a full time study mode included two academic semesters of approximately 13 –14 weeks each. (n=21) Some course coordinators only identified the academic year as the length of their course, however others specified that the length of the course around these two semesters ranged from approximately nine months to 12 months (n=9) to include clinical practice[7] placements). Table 9 identifies the variations in length of courses by mode, full time and part time status of students and the ratio of theory to practice components in courses.

### Theory hours

There was considerable variation in the number of theory hours identified by course coordinators in each course, so much so that results almost appear meaningless in some cases. One respondent running an external course stated that they could not realistically identify the number of theory hours but suggested a figure (2080) that was considerably larger than theory hours in the majority of other courses. Two other external courses also stated comparatively large theory hours: 2160 hours and 1560 hours with three respondents citing theory hours of 600, 916 and 954. The remaining courses gave a range of theory hours extending from 174-400 hours. As demonstrated in Table 9, the course coordinators who estimated large theory hours in their courses were basing this figure on estimations and expectations of student initiated activity in courses offered externally.

**Table 8. Theory hours in courses**

| **Theory hours** | 174-256 | 257-320 | 321- 400 | 600 | 916 - 1560 | 2080-2,160 |
|---|---|---|---|---|---|---|
| **Courses** | 8 | 6 | 5 | 1 | 4 | 2 |

### Clinical practice hours

The number of hours allocated to clinical practice also differed greatly between courses, as did the ratio of theory to practice hours. Some respondents answered this question by stating the minimum

[6] (Ogle et al, 2001 Nursing Education and Graduates: Profiles for 1999 and 2000, with projections for 2001. Report 01/13 to the Evaluations and Investigations Programme, Higher Education Division, Department of Education, Training and Youth Affairs, Canberra; DEST (2001) National Review of Nursing Education Discussion Paper; Senate Community Affairs References Committee (2002). Report on the Inquiry into Nursing.)

[7] There is a recognised commitment by the Australian College of Midwives Inc. (ACMI) to use the words 'midwifery practice' instead of 'clinical' to reflect the role of the midwife (See ACMI Standards for the Accreditation of 3-year Bachelor of Midwifery Programs 2002). In this study, a decision was taken to use the word 'clinical' in designing the questionnaire in recognition of its common use and in the interest of clarity and consistency.

hours students spend in clinical practice placements. The range described by the course coordinators was between 500 –1824 hours with the majority less than 1000 hours. One course arranged 700-900 hours of clinical practice experience, according to individual competency assessment. Supernumerary students undertook fewer hours than students who were salaried to undertake clinical practice experience (See Table 9).

**Table 9: Midwifery education programs by mode, full time/part time status of students, length of program and numbers of clinical practice and theory hours as described by midwifery course coordinators**

| Internal<br>External mode | Fulltime (f/t)<br>Part-time (p/t)<br>mode | LENGTH OF PROGRAM (BASED ON F/T STUDY UNLESS STATED OTHERWISE) | CLINICAL PRACTICE HOURS | THEORY HOURS |
|---|---|---|---|---|
| Internal | f/t | Full 12 months | 1200 | 224 |
| Internal | both | Full 12 months | Supernumerary: 900<br>Employed: 1212 | 247 |
| Internal | both | Full 12 months | 1130 | 224 |
| Internal | both | Full 12 months | 1600 | 364 |
| Internal | both | Full 12 months | Supernumerary: 440<br>Employed: 440 + 5 shifts per fortnight | 916 |
| Internal | both | Full 12 months | 832 | 252 |
| External | both | Full 12 months | 1824 | 954 |
| External | both | Full 12 months | 1032 | 1560 |
| both | both | Full 12 months | 760 | 174 |
| both | f/t | 45 weeks | 640 | 222 |
| both | both | 45 weeks | 1078 | 286 |
| Internal | both | 1 year * | 528 | 276 |
| Internal | both | I year: March to January | 1056 | 180 |
| both | both | Supernumerary: 32 wks<br>Employed: 48 wks | Supernumerary: 1000<br>Employed: 1450 | 340 |
| External | both | 1 year: March - December | 800 | 600 |
| Internal | both | 1 academic year | 656 | 312 |
| Internal | both | 1 academic year | 600 | 400 |
| External | both | 1 academic year | 600 | 312 |
| Both | both | 2 semesters March - Dec | 780 | 312 |
| External | both | 2 semesters March - Nov | 888 | Unable to say |
| Internal | both | 28 weeks | 500 | 320 |

**Courses offered in part time mode only**

| | | | | |
|---|---|---|---|---|
| External | p/t | Full 12 months | 800 | unanswered |
| Internal | p/t | 12 months | 1660-1692 | 256 |
| Internal | p/t | 3 semesters (p/t) | 1008 | 960 |
| Internal | p/t | 42 weeks | 750-900 | 398 |
| Internal | p/t | 4 semesters (p/t) | 45days [360] + 32 hrs | 384 |
| External | p/t | 64 weeks (p/t) | 800-1040 | 180 per unit - total 2,160 |

* In some cases it was not made clear whether 'a year' was an academic year of two 13 –14 week semesters or a full 12 months.

**Clinical practice placements**

Clinical practice placements occurred in different modes: weekly, block, yearly and sometimes a combination of these. Thirteen courses combined supernumerary and salaried experience, eight offered supernumerary experience only and six offered a salaried model only for clinical practice placements. Rates of pay for those who were in the salaried model varied and respondents identified this as an important issue that needs to be addressed. Students in nine courses were paid as RNs at their level of experience/service in nursing. Examples of other arrangements ranged from individual negotiations with employers (3) to being paid at 'Level 1 RN' regardless of the student's experience in nursing (3).

**Types of facilities used by the students for clinical practice placements**

All but one respondent [26] stated that they used tertiary level hospitals for midwifery clinical practice placements. With only a few exceptions, most courses also used regional or rural hospitals, some specifying that these facilities had to have a Level II nursery. Private hospitals were used by all but three courses but four respondents clarified that they only used private facilities to access experience for students in hospital postnatal areas. Students were required to rotate through hospital areas and in some cases through different types of hospitals in order to meet the course accreditation requirements of the local nursing regulatory authority. As identified by Brodie and Barclay (2001), these requirements will vary considerably from one state/territory to another. Rotation was most often driven by the need for students to have experience in tertiary referral centres and Level II nurseries. Students placed in private hospitals needed to rotate into public hospitals in order to access sufficient experience of attending women labouring and giving birth. One respondent identified that competition between universities for clinical practice placements in the same facilities forced students to rotate through different hospitals. In comparison, one respondent identified a system where it was compulsory for students to remain with the hospital to which they were assigned for the total duration of their midwifery education.

Some regulatory authorities did not require midwifery students to engage in community based placements, and 11 courses did not enable students to have placements in areas other than hospital wards. The table below identifies areas where students may have been able to gain 'community experience' in the 16 courses that offered this opportunity.

**Table 10. Summary of identified community placement areas used in midwifery programs** (number of courses = 16)

| |
|---|
| Elective time with independent midwife/midwives [6] |
| Maternal and Child Health Centres/Early Childhood Nurse [5] |
| Community midwifery program [3] |
| Women's Health Centre [3] |
| Family Planning/Sexual Health Centre [2] |
| Community Centre/ Support group [ |
| Mother and Baby Unit/Residential Care for PND Unit [2] |
| Postnatal 'early discharge' program [1] |
| 'Urban Community Nurse' [1] |
| Overseas placement [1] |
| 'Community placement – eg Birth Centre' [1] |
| Reproductive Medicine Unit [1] |
| Medical Practitioner's Rooms [1] |
| Elective in rural hospital [1] |

**Arrangements for clinical practice placements, supervision and assessment**

In most programs, responsibility for the organisation of clinical practice placements rested with the university. There were only five examples reported of a team approach between hospitals and universities to organising clinical practice placements. In some cases, before commencing their midwifery education program, students had to secure a placement with a hospital themselves and then have it approved by the university. In three instances the students were interviewed by the hospitals of their choice.

Arrangements for supervision and assessment varied considerably. There are problems in summarising these arrangements arising from nomenclature, the titles 'university staff', 'lecturer', 'mentor', 'preceptor', 'lecturer practitioner' 'clinical educator' and 'joint university/hospital appointee' being used interchangeably by some respondents. As can be seen in the Table below, staff based in hospitals carried out most of the supervision and assessment of students:

**Table 11. University staff involved in supervision and assessment of students**

| **Identified staff** | **Involved in supervision** | **Involved in assessment** |
|---|---|---|
| University staff | 5 (3 only occasionally) | 4 |
| Joint university/hospital appointee | 15 | 13 |
| Lecturer | 7 | 7 |
| Mentors/preceptor | 21 | 21 |
| Lecturer/practitioner | 5 | 4 |
| Clinical educator/instructor | 6 | 5 |
| Buddy system: hospital staff | 1 | 1 |

**Professional development opportunities for preceptors/clinical practice educators**

Twenty-three respondents described some system whereby their university provided professional development opportunities for preceptors/clinical practice educators. In two sites the university was not involved because the hospitals ran their own preceptor workshops and in another instance this was provided by the state health services. Twelve of the universities identified that they ran preceptor workshops or professional development workshops for staff who work in practice areas.

Although two universities clearly stated that the workshops were not compulsory the researcher who carried out the telephone survey reports that her impression was that this was also the same for a number of other universities. Of the four universities who stated that they did not provide professional development opportunities, three gave reasons to justify this situation. In each case, responsibility for this task rested with other institutions, namely, the state health service, the hospital and 'each clinical unit'.

**Identified difficulties or problems experienced by students in clinical practice placements**[8]

Participants were asked to list the difficulties or problems experienced by their students on clinical practice placement. While it was recognised that not all students experienced problems, nine themes were readily identified in the data as causing problems for students. Quotations from data are included in the boxed text below that exemplify these problems and illustrate these themes. The themes have been arranged in order of priority according to frequency of issues mentioned.

**Table 12. Examples of issues associated with difficulties experienced by students in clinical practice placements as identified by midwifery course coordinators in order of priority in terms of numbers of examples cited**

| **Lack of support/supervision** (15) |
|---|
| *Some students don't feel well supported by midwives. This could be because the midwives are unable to interpret the competencies at a beginning level, but it's also because of the large numbers of casual staff and the inability to get a regular preceptor.* |
| *Questioning can make some midwives feel threatened that the student is challenging their knowledge base and so leads to reluctance to teach* |
| *Because students are supernumerary there is a cultural perception that they are not part of the organization* |
| *There are difficulties related to responsibility and partnership. Hospitals have a situation where there are a multitude of students and the preceptors don't do what is expected of them even though they are given an outline of their role.* |

| **Horizontal violence** (13) |
|---|
| *Horizontal violence - students are treated fairly poorly. For example, they are put down, their skills are not valued, it's made difficult for them to ask questions, and they are ridiculed in front of patients.* |
| *Horizontal violence - the socialization in the midwifery clinical area, for example, bullying and harassment are the greatest causes of dissatisfaction.* |
| *Horizontal violence- some students feel they are picked on and treated rudely; no credit is given for them being an RN* |

[8] Further concerns related to clinical placements are described in the section of these results where course coordinators described the barriers to effective midwifery education.

| **Staffing issues** (12) |
|---|
| *The hospitals are short staffed which leads to large workload for the students, for example, eight women plus their babies can be allocated to one student midwife.* |
| *Hospitals being short-staffed means that experienced midwives are unable to help. They are also unable to sign off activities in the student portfolios because they are too busy.* |
| *All units are stressed because of staffing problems. Staffing levels are unrealistic; staff morale is low which contributes to their behaviour.* |
| *There is competition with other students from other health disciplines, for example ambos and doctors* |

| **Competing Demands** (9) |
|---|
| *They have to work as nurses while also trying to complete their studies and midwifery practice placements.* |
| *They need to work elsewhere to make ends meet and they burnout with having to meet the demands of study, finances and family.* |
| *There is no funding for the release of students [from their employment in nursing] for clinical placements and residential learning schools.* |
| *The greatest cause of attrition rates is the supernumerary aspect of clinical, which causes financial constraints.* |
| *Distance is a problem –many students live a long way away from clinical placements* |

| **Rostering issues** (8) |
|---|
| *There is inflexibility over hours and placements, often due to the constraints on hospital staff, for example, there are limited staff who are preceptors and other students are also needing attention.* |
| *Rostering problems include them being rostered on university days and also put on night duty the night before, also split days off (using them as fill-ins).* |

| **Learning needs of the students are secondary to the hospitals needs (6)** |
|---|
| *There is tension between students' needs and service needs particularly when students first start employment. As their learning needs decrease this isn't as acute.* |
| *The hospitals don't bond with the university. They feel they are ultimately responsible to the patient and so the student always comes a long second.* |
| *Supernumerary students feel exploited whereas paid students don't.* |

| **Placement difficulties (5)** |
|---|
| *Placements themselves are difficult; every university does different models of clinical; for example two out of three tertiary hospitals may be directly linked to the university, which means the other universities cannot get into the hospital to get clinical placements. If they do get in they just get the crumbs, therefore it's not the best educational experience for the students.* |
| *Some universities use salaried models some don't. Salaried students get preference. Students from universities with exclusive agreements with hospitals get preferential treatment over other students because they are paid although they do the same work. Students feel they are treated differently* |

| **Philosophy conflict** (5) |
|---|
| *The philosophy of the agency differs from that of the university. It's the medical model versus a woman centred approach.* |
| *There are difficulties contracting available quality experiences. There is so much intervention; the students are not seeing so much of the normal. It's getting harder to find quality experiences with fewer interventions.* |
| *There is a yawning chasm between what they learn in regards to midwifery models and what they see in the hospitals.* |

| **Unrealistic expectations of staff regarding students** (3) |
|---|
| *Clinicians are not sure of what students should be able to do. They have high expectations of them, even on their first clinical placement.* |
| *Students are left in situations they shouldn't be in and asked to do things they shouldn't do, but students can also cause problems. After limited theory and no clinical experience, they can challenge everything.* |

**Minimum clinical practice requirements to gain the award**

When asked to identify the minimum practice requirements required to gain the award, the course coordinators generally referred the researcher to the requirements of their local regulatory authority, usually referred to as the 'Nurses Board'. The seven course coordinators who offered a full overview of the minimum clinical practice components of their courses highlighted the differences that exist between state and territory standards in relation to the minimum practice requirements of midwifery education programs and how these become reflected in the courses.

**Table 13. Examples of minimum practice requirements in seven courses and diversity of description**

| | |
|---|---|
| **Course 1**<br>Complete the 8 units<br>Complete the clinical component<br>Complete the Nurses Board requirements<br>Minimum of 25 abdominal examinations<br>Minimum of 25 births/witness<br>Minimum of 20 conduct of birth<br>Total care of labouring women:<br>Primips: min.10, Multips: min. 5<br>Witness/assist resuscitation of neonate<br>Minimum 10 Normal Vaginal Births<br>Minimum of 10 Caesarian Sections<br>Assist at a minimum of 2 C/S<br>Minimum of 10 supervision/teaching inhalation analgesia<br>Clinical assessment abdominal examination/VE: min.10<br>Care of a sick/preterm neonate min.30 | **Course 5**<br>10-15 days in antenatal<br>40 days in birthing<br>15-20 days in postnatal<br>10 days in neonatal intensive care<br>20 Normal Vaginal Deliveries<br>10 Vaginal Examinations<br>10 receptions at birth<br>10 pain managements<br>3 witnesses before birth assistance |
| **Course 2**<br>Students have to meet all ACMI Competency Standards | **Course 6**<br>832 clinical hours plus the state's Nursing Council requirements |
| **Course 3**<br>3 witnesses prior to assisting with births<br>20 births<br>5 Vaginal Examinations<br>10 receive of infant<br>Planned pain management of 5 women in labour<br>25 clinical days in labour and birth<br>20 days in postnatal<br>10 days neonatal level 2 Special Care Nursery<br>10 days community including continuity of care for 3 women | **Course 7**<br>Antenatal clinic 80 hours<br>Women's health 8 hours<br>STD clinic 8 hours<br>Family Planning 8 hours<br>Antenatal ward 48 hours<br>Postnatal ward 120 hours<br>Birth suite 120 hours<br>Domiciliary midwifery 40 hours<br>Community 52 hours |
| **Course 5**<br>Antenatal education 8 hours<br>Maternal and child health 12 hours<br>Medical practice 40 hours<br>Aboriginal and Islander Health 40 hours<br>Birth Suite 132 hours<br>Antenatal 96 hours<br>Alternative birthing 24 hours<br>Postnatal 120 hours<br>Community health centres 8 hours | |

**Payment and qualifications of midwifery educators/preceptors in the clinical practice area**

Whilst some preceptors were paid in three programs, and all preceptors were paid in four programs, preceptors were not paid in the majority [20] of programs. In nine programs, people referred to as either: clinical lecturers, instructors, joint university/hospital appointees, or midwifery educators were paid. Three examples were given of health facilities, as opposed to individuals, being funded for clinical practice preceptorship: namely through a contribution from the university, through a charge to the university of $30 per hour per student or through government funding:

When asked if there were any education or experience requirements for those who supervise students in the clinical practice areas a wide range of responses was elicited. Some of these appeared to have the status of formal criteria; others were more subjectively derived. These are listed in Table 14.

**Table 14.**

**Range of education and/or experience requirements for midwifery practice educators/preceptors**

| |
|---|
| Completion of a hospital/university preceptorship program |
| Deemed clinically competent |
| Tertiary qualifications/a Masters |
| A commitment to teaching |
| Experience/qualifications in teaching/education |
| A senior position in the hospital such as ‘CNS’, ‘CNC’, ‘Assistant NUM’ or ‘NUM’ |
| An appreciation of students and enthusiasm for teaching |
| Five years experience in midwifery, teaching and leadership |
| Effective communication and interpersonal skills |
| No requirements at all |
| A personal practice portfolio that reflects the ACMI competencies. |
| Requirements specified by the local regulatory authority |
| Interested volunteers with more than 2 years postgraduate experience as a midwife |

**Use of ACMI Competency Standards for Midwives for assessment**

With four exceptions, all programs used the ACMI Competency Standards for Midwives or a set of competencies that included these, for assessment. In the four programs where the ACMI competencies were not used, the registering authority dictated the competency standards.

**Course curriculum issues and specific placements**

All respondents identified that their curriculum addressed a wide range of social and professional issues. In one way or another, all courses addressed contemporary areas of high concern that were listed in the questionnaire:

**Table 15. Issues covered in all course curriculum documents**

| |
|---|
| Rural and remote maternity services |
| Aboriginal and Torres Strait Islander health |
| Cultural diversity in midwifery care |
| Continuity of care models |
| Following women through pregnancy, labour and the early postnatal period |
| Birth centre care |
| Home birth |

Placements that enable students to gain experience in any of the above areas were identified as problematic. On the whole placements in such areas were electives that the students had to organise

and fund themselves, particularly where experience of midwifery in home birth settings was concerned. Examples of comments made by participants included the following:

> *The opportunity is available for the students to do these options as an elective if they have a passion. However there is a cost involved that needs to be met by the student, which would make it prohibitive for some.*
>
> *Birth Centre Care and Home birth [placements] are difficult to provide mostly. Rural and remote [placements] are the same. It's about the students' choice and availability. The students don't follow women through. They used to do this but it became overwhelmingly difficult.*

There were a number of difficulties identified with placing students in rural and remote maternity services. These included the pressure to meet clinical practice requirements in areas where maternity service provision is occasional or low volume, the competing obligations on students, and in one state, the fact that the Registering Authority has to approve each facility prior to placement of students.

**Table 16. Opportunities for placements within the curriculum**

| Placement area | Placement offered | Elective option* | Not offered |
|---|---|---|---|
| Rural and remote maternity services | 13 | 3 | 11 |
| Aboriginal and Torres Strait Islander Health | 8 | 7 | 12 |
| Cultural diversity in midwifery care | 21 | 1 | 3 |
| Continuity of care models | 17 | 6 | 4 |
| Following women through pregnancy, labour and the early postnatal period | 23 | 2 | 2 |
| Birth centre care | 14 | 8 | 5 |
| Home birth | 4 | 12# | 11 |

* Elective option includes where course coordinators identified that it depends on whether the hospital the student is placed in offers this experience. It also includes situations where the student organises this experience (as opposed to the education provider).

# Placements with midwives providing home birth services were identified as rare, and almost always organised and funded by the student.

### Extra information about courses

In response to the question, 'Is there anything else you would like to tell us about your course?' six respondents declined to offer any extra information and one identified that their program had only just started and had not been evaluated yet. Most were enthusiastic about their courses and were proud of what they saw were the strengths and unique features. For example, one coordinator spoke of a course designed for rural and remote students where lectures were offered in blocks and flexible arrangements enabled students to complete as much as possible of their clinical practice placements near to their homes. Achievements that some course coordinators were keen to share with the researchers are summarised in Table 17.

**Table 17. Strengths of courses identified by midwifery course coordinators**

| |
|---|
| A curriculum focused on 'the normal process' |
| Teaching by midwives only, not doctors or obstetricians |
| A theoretical grounding before students go into practice that follows the 'sequential nature of birth' |
| Applications exceeding places and good retention rates |
| Good collaboration between the university and the area health services regarding curriculum development, teaching, assessment and marking |
| Cultural diversity reflected in an external program developed by a collaborative team |
| External course well supported by university staff through telephone contact |
| The strength of a small cohort where students can be 'nurtured into midwifery so that they stay in midwifery |
| Having a Clinical Chair in Midwifery with a graduate clinical practice school on a hospital site to prevent a diverse gap between education and clinical practice. |
| Students only have to do 5 days in SCN |
| Students are clinically competent and have a good focus on woman centred care and midwifery models |
| An on line course offered in mixed mode |
| An employed model that is responsive to student and industry preferences in a variety of settings that have not previously been able to support students such as private Level 2 hospitals and rural hospitals. |

On the other hand, some course coordinators disclosed issues about their current programs that caused them concern. These included difficulties preparing students for the full role and sphere of practice of the midwife, in particular, the limitations of a one year program where placements were in fragmented acute care models as opposed to midwifery models of care.

### Consideration of plans to change courses

Ten midwifery course coordinators described an ongoing process of evaluating and changing their program to reflect the identified needs of students and industry, as well as contemporary midwifery practice. An example was given of a curriculum development committee addressing the language of course documents and nomenclature in an attempt to reflect a more woman centred approach to practice and understanding.

Several respondents identified that their university was changing the length of the course. Examples included moving to a four term academic year; a model that included one full day on campus and four days a week employment in clinical practice over 47 weeks; and a three year Bachelor of Midwifery with entry for both RNs and non-RNs. Other projected changes included: introducing a paid clinical practice component; increasing clinical practice hours; changing the course from a Masters to a Graduate Diploma and collaboration between universities over shared curricula. One respondent described a long term goal to change the content of the course for RNs to ensure that they will reach the same standards as graduates of the 3 year Bachelor of Midwifery.

### University staff teaching arrangements

We investigated the numbers and qualifications of university staff who taught in midwifery programs. Almost all had midwifery qualifications (102) and half of these (56) were involved in clinical practice supervision. Nine course coordinators identified using a total of 22 teachers who are not midwives in specific subjects such as: 'Science', 'Physiology', 'Bioscience', 'Behavioural Health', Research, 'Core subjects', 'Guest speakers' and an 'Elective subject'. Four course coordinators identified two or three university staff who were not midwives but who taught in unspecified subjects.

### Course Coordinators qualifications

The course coordinators demonstrated a commitment to academic achievement as demonstrated in Table 18.

**Table18 Course coordinators' qualifications***

| | |
|---|---|
| Highest qualification Bachelor | 3 |
| Highest qualification Masters | 17 |
| Highest qualification Ph.D. | 4 + 3 (submitted) |
| Qualification in education | 11 |
| Coordinator studying | 12 Ph.D., 4 Masters,1 Grad Cert Ed,<br>1 Grad Dip (Psychology) |
| Coordinator not a member of ACMI | 3 |

***** Information not received for one course coordinator and question not addressed in a program where each subject has a different coordinator

**FINDINGS: Section 2**

**Barriers to providing midwifery education and strategies to overcome these barriers**

In line with the major research questions of the Australian Midwifery Action Project (AMAP), the midwifery course coordinators were asked to list what they saw as the barriers to providing quality midwifery education and strategies to overcome these barriers. The main concerns listed centred on barriers associated with providing appropriate clinical practice placements (44), financial pressures for students (24), the organisation and delivery of services and implications for students (24) and teaching and learning difficulties (18)[9]. Mostly the strategies were a removal of the identified barriers.

**Barriers associated with clinical practice placements (44)**

Course coordinators consistently expressed concerns about the lack of both appropriate role models and midwifery models of care that might enable students to have adequate experience to become competent, confident practitioners. A situation was described where, in many areas, there was insufficient exposure to 'woman centred care', team midwifery, birth centre care, community placements and cultural diversity:

> *The curriculum may promote midwifery models of care, but the reality that students confront on placement is usually very different.*

The lack of appropriate placements in midwifery models was identified as a major barrier to learning:

> *The culture of the hospital environment is not conducive to midwifery.*

Some respondents stated that the fragmented models of care in maternity units mirror nursing models as opposed to midwifery models. The perceived focus on sickness and interventions was seen to reinforce students' previous experience in nursing and their tendency to seek and prioritise medical, as opposed to midwifery, knowledge.

Rural students were described as particularly disadvantaged by the need to travel to tertiary units to gain appropriate experience. This involved issues of cost, time and distance from families. Where students had placements in rural and remote units, they often needed to spend large amounts of time working as nurses looking after general patients.

Staff shortages in hospitals were cited as the reason that adequate supervision for more than a minimal numbers of students was not offered. The lack of suitably qualified and experienced midwives to supervise students was seen as being compounded by the decreasing number and size of hospitals and a reduction in the birth rate. Staff shortages also meant that:

> *Experienced midwives are unable to engage with the activities in the students' learning guides and portfolios because they are too busy.*

Continuity with experienced preceptors was further reduced due to an increase in the casualisation of the workforce. An example was given of one student midwife having to look after eight women and their babies on a postnatal ward without support or assistance.

The lack of teaching experience of midwives and clinical practice teaching models were cited as problematic:

> *There is an assumption that midwives have an ability to teach and not everyone should be teaching.*

The commitment of preceptors and clinical practice staff to midwifery education and support was seen as lacking, with some midwives being unwilling to be preceptors or to engage in teaching.

Difficulty in securing placements for students was seen as a major barrier, particularly where more than one university is competing for placements. The number of placements has decreased dramatically since midwifery education became university based. Competition for placements was especially acute where students were not employed and where midwifery staff were preceptoring other health workers, for example, ambulance personnel, medical students, nurses and rural midwives on exchanges. Examples were given of busy hospitals limiting places to only one student on each shift

[9] Numbers in brackets represent the number of times an issue in this category was listed by the midwifery course coordinators.

in each area, particularly where students were supernumerary and the hospital *'has no vested interest in them'*.

Course coordinators described low morale in units affecting students with many instances of horizontal violence, hostility and poor support for students cited. Midwives were seen to often have unrealistic expectations of students. Examples were given of prospective students and university staff receiving a poor reception or hostility when trying to locate and organise placements. A resistance to university education from some practising midwives was described, with a perceived lack of understanding of the importance of knowledge development in educating midwives to be practitioners in their own right.

**Barriers associated with teaching and learning in midwifery education (24)**

One year was seen as limited time in which to prepare midwives for practice. Within universities, midwifery is still seen as a specialty of nursing and course coordinators identified that the particular requirements of midwifery were not addressed or funded. Unlike postgraduate studies in specialties of nursing where students are building on qualifications and experience in nursing, midwifery programs were seen as a preparation for a new discipline. It was therefore described as inappropriate to place midwifery programs in postgraduate nursing degrees:

> *… locked into 12 months when it would be better over at least 18 months.*

Some coordinators described their concern about the inadequate length of courses in terms of having insufficient time to address the fact that nurses have been *'socialised into a nursing model'*. The accreditation of programs by Nurses Boards as postgraduate nursing programs was also cited as a barrier:

> *You are confined by what gets accredited. You cannot be as innovative as you might like to be.*

Some course coordinators described a lack of control over the planning of placements with a resulting inability to make sure that theory and practice were integrated. They saw the organisation of midwifery education in universities and the systems in the health services as *'tending to widen the theory/practice gap'* with poor communication between universities, hospitals and area health services and competitiveness for placements compounding this. Examples were given of the needs of universities and hospitals taking precedence over students' needs in planning and organisation:

> *Even where hospitals make a commitment to quarantine money for students this does not always work when students leave because of financial constraints within the hospital. Funds are redirected away from students.*

**Barriers associated with the organisation and delivery of services and implications for students (24)**

Course coordinators identified a culture that is far from conducive to educating a competent, confident midwifery workforce. The medicalisation and privatisation of childbirth in Australia was a constant theme of the midwifery course coordinators' comments and concerns.

The shortage of midwives, with low morale, increased workloads, poor support from managers, double shifts and evident 'burnout' were seen as issues that are not conducive to the retention of students or new graduates:

> *Midwives are unable to work to the full potential of their role in midwifery models of care and students are exposed to high intervention rates and very little normal midwifery.*

Course coordinators described a situation where obstetricians and GPs (as opposed to midwives) were funded to provide care for women who are 'low risk' and midwifery education was poorly resourced when compared to medical education. In rural areas, they identified insufficient opportunities for midwives to practise when doctors withdraw their services.

Current regulation was seen as a barrier to midwifery education, with the accreditation of midwifery programs seen to be subsumed within inappropriate nursing regulatory frameworks that do not match academic accreditation processes. Course coordinators expressed frustration that, in spite of government recommendations (NHMRC 1996), midwives are still unable to order and interpret tests

and have limited prescribing rights. Furthermore, area health services are often not implementing the strategic planning for maternity services that has been identified to address many of these issues.

**Barriers associated with financial pressures for students (18)**

**Financial hardship for students was seen as a major barrier to recruitment and retention:**

> *Students who have left the course because of financial constraints have expressed their desperate situation.*

This was seen as particularly apparent in courses that are full fee paying and do not include a concurrent employment option in a maternity unit. Course coordinators described a situation where the lack of financial support was driving students to undertake part time midwifery courses with some taking several years to complete.

> *Many students continue to work as nurses throughout their midwifery education, some full time, as they have no other source of income. This is very demanding and confusing and doesn't consolidate learning adequately.*

Even where there was the opportunity for HECS, midwifery education usually involved a loss of earning, plus expenses associated with additional fees, books and travel. As previously described, rural students were seen as particularly disadvantaged by having to travel long distances to gain appropriate experience, in terms of cost and time away from their families. Course coordinators identified that difficulties experienced by rural and remote students were often compounded by inflexibility about how and where they were able to do their placements.

In terms of recruitment and retention, respondents identified that there is little financial incentive to enter the midwifery profession. Since midwifery education is at postgraduate level, there is a delayed entry into courses and students tend to be older with extended financial and family responsibilities.

## STRATEGIES TO OVERCOME BARRIERS

Course coordinators identified that systems change needs to happen at the top level of administration and policy development to promote and fund effective midwifery education and the management of maternity care. This was seen to include the development of a system to promote collaboration and commitment between all parties concerned to alleviate the breaking down of lower level agreements that negatively affect individual students.

**Strategies associated with clinical practice placements**

Midwifery course coordinators stated that they would like to see more collaboration between area health services, universities and health service providers to increase the number of appropriate clinical practice placements for students and promote joint 'ownership' of planning and organisation. This would include devising systems to fund university support for preceptors and educators. The idea of seamless integration of teaching by academics and clinicians was promoted where academics have the right of access to hospitals and clinicians lecture students and are involved in overall assessment. Structures identified to support this included ongoing education and support for both university staff and clinicians. Regular meetings were seen as a strategy to improve communication and promote equal opportunities for all students. Stronger affiliations were advocated to prevent the 'under cutting' related to competition for placements. There was a suggestion that the planning of multidisciplinary student placements could be a collaborative venture with regard to prioritising opportunities for flexible and block placements. Most course coordinators favoured the option of paid employment for students but some advocated funding to enable full time students to have supernumerary status in clinical practice areas.

**Teaching and learning strategies**

The three-year Bachelor of Midwifery was identified spontaneously by approximately a quarter of the respondents as an important strategy to address many of the barriers to midwifery education. This included the need for midwifery to be recognised as a profession in its own right by universities. One respondent though had concerns about midwifery education *'separating from nursing'* in terms of capitalising on established relationships and infrastructure and addressing the need for 'multiskilling'. This respondent thought that a 4-year double degree, *'a nursing degree with an extra year endorsement as a midwife'* was a more appropriate way forward.

There was support, spontaneously offered, for extending the length of the program to at least 18 months duration with some advocating that at least one year of that time should be in full time, paid employment in a maternity unit. Several respondents saw strategies to offer flexible learning, using web-based materials, as important, including computer skills education for students who needed to develop these.

Collaborative approaches to teaching and learning between university staff and clinicians, with funding for joint appointments, were identified as important. According to some course coordinators, this should involve clarifying the teaching and learning model, in particular the selection criteria of the midwives who are facilitating clinical practice. Some respondents thought that all midwives should be supported to teach students as part of their professional responsibility, whereas others thought that it was important to release designated educators to spend time with students in clinical practice areas. One respondent proposed that establishing clinical practice schools with a chair in midwifery would have a synergistic effect.

Other suggestions for strategies to overcome barriers raised by individuals included:

Student, midwife and academic exchanges with other national or international organisations

Increasing the numbers of available midwives by offering refresher courses

More doctoral programs in midwifery

University support and allocated time for staff to be involved in research

Ongoing evaluation of courses to ensure an evidence based, contemporary approach

Reclaiming of feminist / women centred sociological philosophies and language that is woman centred.

Social health and wellness models of teaching and learning

**Strategies to relieve financial pressures for students**

An employment model was seen to assists students with finances as well as enabling *'a sense of them belonging'* in clinical practice areas. Funded placements, scholarships, HECS arrangements and subsidies were suggestions for funding arrangements. Extra funding for travel and accommodation and flexible arrangements for placements was seen as particularly important for rural and Indigenous students. Funding arrangements that would make it easier for student to study full time were seen to be beneficial in terms of enabling students to focus on midwifery during their education.

**Strategies associated with the organisation and delivery of services**

An increase in publicly funded facilities that offer midwifery models of care was seen as one of the most pressing strategies to promote quality education programs. Course coordinators expressed frustration with the government's prioritising of doctors' needs and apparent lack of commitment to developing and funding midwives as primary care givers for the majority of women throughout their experience of pregnancy, labour and the early postnatal period.

The following quotation encapsulates the tone of much of the data:

> *More midwifery models of care need to be established and funded. I wish to stress that I mean midwifery models, not maternity models. The two major criteria are continuity of care and midwifery led care, not obstetric led care.*

More flexible systems of care and rostering were seen as benefiting students as well as practising midwives. One respondent suggested that:

> *There needs to be a massive publicity campaign that encourages midwives to nurture the up and coming generation of midwives.*

Others suggested campaigns to raise the profile of midwives in the community and promote midwifery models of care. There was a plea *'not to set students up as change agents'*, political activity for change being seen as the responsibility of individual midwives and the ACMI. One respondent expressed *'caution about the political move of midwifery away from nursing'* being antithetical to positive collaboration. In contrast, another respondent proposed:

*… the separation of nursing and midwifery within university and hospital settings as an important strategy to enable the recognition of different philosophies..*

## DISCUSSION

In 1986, Lesley Barclay provided a thorough historical analysis of midwifery education and practice in Australia. She identified issues that hinder Australian midwives from practising fully according to the World Health Organisation's (WHO) definition of a midwife (WHO 1966). Many of these issues are still relevant in 2002 despite the aspirations many held that moving midwifery education into universities would improve the previous situation. Persisting problems over 20 years can be summarised thus:

Rules and regulations in most states do not define or describe midwifery and do not set appropriate standards for midwifery education and practice. Regulation is idiosyncratic, inconsistent and often renders midwifery invisible within nursing. This is compounded by the limited view of midwifery demonstrated by some nursing leaders who are in a decision-making capacity on behalf of midwifery;

Midwifery education is inconsistent between states and needs to be reviewed since reciprocal registration is granted. There is evidence of major differences in the award, and length of programs as well as the theory, practice and assessment elements of midwifery courses across Australia;

The economic competition of private medicine, elitism, sexism, insurance systems and the alignment of nursing with medicine have all combined to erode the role of the midwife and support the medical dominance of healthy as well as compromised pregnancy and birth;

There is a poor use of midwives' skills in many hospitals and few opportunities for midwives to practise autonomously across their full range of accountability and responsibility;

The issue of 'direct entry' midwifery education should be re-examined in light of international developments in midwifery and the 'dubious cost-effectiveness' of the problems associated with current midwifery education courses meeting workforce requirements.

Nearly twenty years later than when data was collected nationally for the previous study (Barclay 1986), new issues have arisen. In the early 1980s there was an oversupply of midwives being prepared for practice. Today, the converse appears to be true and this study raises questions about insufficient quality control and monitoring of the transfer of midwifery education to universities by the profession and regulating authorities. Midwifery educators tend to be isolated from practice areas within universities rather than strongly clinically located and 'grounded'. Over half of the university staff involved in midwifery education are not also involved in clinical practice supervision. Most midwifery course coordinators do not see themselves as sufficiently powerful to 'override' school of nursing priorities in programs or claims on resources. They described nursing education priorities taking precedence in educational institutions and regulating bodies, and situations where decisions and leadership have not necessarily reflected the professional midwifery or maternity services needs as well as is required. The leadership role of maternity services or the capacity to work through a team approach with universities has been diminished or abdicated in many parts of Australia. The quality of clinical teaching and experience has suffered as a result.

Area Health Services and facilities need to work with universities to ensure that midwifery education programs meet service needs (NSW Health 2000a, 2000b). The lack of collaboration between the health industry and universities appears to exacerbate student isolation and does not assist them feel or become members of a team. The lack of investment of skills and resources in programs now in universities is to the detriment of quality of caring for students who are potential colleagues and midwives. The supernumerary and part time status of students can contribute to this. Rural student are particularly disadvantaged by the need to travel to tertiary units to gain appropriate experience. This involves issues of cost, time and distance from families.

### Midwifery workforce issues

The AMAP study raises concerns that are particularly pertinent when considering workforce calculations for the future of midwifery services in Australia. It appears that workforce shortages and the mal-distribution of age groups in the Australian midwifery workforce (Tracy et al 2000) are not being addressed in current enrolments or by the employment patterns of new graduates. Calculations

of the projected annual numbers of graduates from courses are problematic given the large number of enrolled *part-time* students who may take several years to complete their studies in some cases.

Previous workforce calculations have not differentiated the 26 postgraduate courses for qualified midwives from the 27 courses for initial authorisation to practise midwifery and have therefore overestimated the number of potential graduates entering the midwifery workforce. For example, a report prepared for the Department of Education, Training and Youth Affairs, Canberra identifies 53 postgraduate [nursing] courses in midwifery and from this figure projects 772 graduates for the year 2001 (Ogle et al, 2001). This is clearly an overestimation in terms of workforce planning and identifying the number of new midwives entering the workforce, which, by conservative estimates based on the findings of this study, is likely to be less than 450 per annum. An earlier paper provided by the AMAP researchers (Tracy et al 2000) relied on similar government reports in attempting to profile the midwifery workforce and therefore also overestimated the number of midwives being educated for initial authorisation to practise.

Serious concerns are also raised here about the number of graduates who did not obtain employment in midwifery. These findings are in keeping with a report on midwifery graduates in New South Wales (NSW Health 2000b), which identified that 30% of newly qualified midwives did not seek midwifery employment on completion of their midwifery education program. As in this study, the suggestion was that this might be course-specific, and not generalisable, therefore requiring further investigation. The fact that attrition rates are not consistent across courses suggests these can be reduced. Issues identified in NSW for the attrition of new graduates included lack of support, the stressful nature of the course, failure to acknowledge prior experience and horizontal violence (NSW Health 2000b). The midwifery course coordinators in this study also identified all of these factors as barriers to effective midwifery education.

Waldenstrom (1997:13) has also highlighted the discrepancy between the number of Australian midwives graduating and the numbers who actually practise midwifery and has suggested that 'a better education and a more extended role might limit the numbers who abandon midwifery'. In her opinion, attrition rates appear to be related to the quality of education and clinical experience received by students. This suggestion is supported by Mander (1986) based on results of a longitudinal study of the employment decisions of nurses who undertook midwifery education in Scotland, beginning in 1980. The majority of qualified midwives were working outside of midwifery and only a quarter of those who were qualified were still practising midwifery. The respondents suggested changes to the organisation of midwifery services as the main strategy to address retention. Mander's (1986) study demonstrated that new midwives with longer nursing experience were more likely to leave midwifery and that the converse applied, in that those with little nursing experience were significantly more likely to practise as midwives. Student midwives with higher educational attainments were significantly more likely to practise midwifery on qualifying and the study suggested that lower age may be associated with continuing midwifery practice. Lack of support for new graduates featured large in the interviews as it did in the study of new graduates carried out recently in New South Wales (2000b).

Students need support and guidance to develop a sense of team contribution and collaboration. Several studies have highlighted the need to support and nurture student midwives (Begley 1999a 1999b, 2001, Jackson 1995, Yearley 1999) in order to address the potentially stressful nature of student midwives' experiences, particularly around the hostility of qualified staff (NSW Health 2000b, Begley 2001). Other sources of stress cited by student midwives include anxiety regarding finding work on completion of study, organisation of the learning environment, perceptions of poor practice, long hours, poor job prospects, inadequate funding of educational resources, low wages, poverty and home versus study demands (Cavanagh 1997a, 1997b, Wallis 1996). Litchfield (1997) acknowledges the stress of being a student midwife and suggests careful time and task management as strategies to reduce stress and enhance confidence.

Approximately three-quarters of midwifery course coordinators in this study reported under enrolment on courses and at least two stated that their numbers are decreasing. The recruitment of nurses into midwifery courses has proved problematic in other comparable western countries, notably the United Kingdom. However, in such countries (and as demonstrated recently in Australia) recruitment to three and four year 'direct entry' programs remains competitive with reports of at least 5-13 applicants for each place on offer in the UK where the majority of courses are now of three and four years duration (UKCC 1999). In the UK, a government directed system ensures that the education of midwives addresses workforce requirements. The government gives funding and directives to the 'Trusts' (health service providers) regarding the numbers of midwifery students who should receive practice placements. The Trusts then contract with the universities of their choice who will provide the

midwifery education program. Unlike the Australian system where according to this survey there are frequently difficulties securing practice placements for their midwifery students, the UK system ensures that midwifery education is driven by service provision and that practice placements are assured within all programs.

Midwifery course coordinators identified workforce shortages as a major barrier to providing effective midwifery education, with a lack of supportive preceptors who are consistently available for students. Staff shortages limit the number of placements that are possible and were blamed for the prevalence of 'horizontal violence' associated with attrition rates. According to the midwifery course coordinators, workforce shortages are directly related to a system where hospitals themselves no longer invest in the education of their workforce and therefore less often contribute to placement provision, competency development and the retention of students in the workforce.

**Concerns about standards of midwifery education in Australia**

The AMAP Education Survey confirms concerns expressed by others that there is no overall consistency in the level of award, duration, or design of midwifery education programs, both nationally and within each separate state/territory (Hancock 1992, Chamberlain 1998, Glover 1999a, 1999b, Tracy et al 2000). An absence of midwifery specific regulation regarding standards for the accreditation of programs has led to these inconsistencies (Brodie & Barclay 2000). Strategies for midwifery educational reform that address workforce needs in Australia are originating from the professional body currently in the form of national standards for the accreditation of three year Bachelor of Midwifery programs (ACMI 2002). However, there are no national or state and territory jurisdictional commitments, incentives or requirements to comply with these at present.

Concerns regarding the standard of Australian midwifery education are raised by this study. Previous authors (Waldenstrom 1996, 1997, Chamberlain 1998, Leap & Barclay 2002) have identified that the midwifery practice component of courses is less than that which is mandatory in other countries for courses leading to licensed midwifery practice and legitimate authority to take responsibility for care. In Australia, as elsewhere, midwives are licensed so they must be prepared at a level that enables them to function as practitioners in their own right, without having to undertake further education or training. According to the international definition of a midwife (WHO 1966), graduates of midwifery education programs should be capable of taking responsibility for the total care of a woman (and her baby) throughout the woman's pregnancy, labour and birth, and the early postnatal period, referring to other health professionals only when complications arise.

This study highlights inconsistencies in the minimum practice requirements of Australian midwifery education programs. Whilst most states require proof of achievement of both competencies and minimum practice requirements, in some states competency based assessment is the only requirement. The way this is implemented gives cause for concern. There is the potential for a situation where a preceptor could determine that a student is 'competent', even though the student has attended a minimal number of births. Glover et al (2001: 433) cite an example where a student could not get employment in her country hospital on completion of her midwifery education 'as she did not have enough experience as a midwife'.

The maximum number of births that Australian midwifery students are required to participate in is twenty. Brodie and Barclay (2001: 106) point out that all current assessment regulations for midwifery fall well short of those required by the regulating bodies of other industrialised countries. They cite as an example the requirement in Europe for midwives to participate in at least 40 births and in Canada 60 births, before receiving registration. Brodie and Barclay (2001) also point out that in the United Kingdom, Canada and New Zealand, regulatory Boards use agreed national criteria to accredit, not only curricula, but also teachers, facilities and services. In these countries regulatory frameworks ensure that theory and practice are integrated in equal proportions in programs and that adequate staff to student ratios are maintained in clinical areas.

Midwifery course coordinators lamented the lack of opportunities for students to participate in midwifery models, including birth centre care in hospitals. Across the western world, the increasing use of technology in childbirth and escalating caesarean section rates limit the opportunity for students to learn about normal childbirth (Davies 1996, Hunt 2000). Concerns about the mismatch between ideology and the realities of mainstream maternity service provision were expressed in this study. These concerns have been explored by Barnes (1997) who describes Australian midwifery students

struggling to develop a 'woman centred' approach to care in the light of the increasing medicalisation of childbirth, in particular, rising epidural and caesarian section rates.

National and international research has demonstrated that where midwives are able to respond to the identified needs of women and provide a personal and continuous service through pregnancy, birth and the early weeks thereafter, they report an increased sense of satisfaction and autonomy. Furthermore, the experience of working in such models of care may transform approaches and attitudes to practice (Brodie 1996, Homer et al 2000, Kenny et al 1994, McCourt & Page 1996, Page 1995, Rowley et al 1995, Waldenstrom and Turnbull 1998, Stevens & McCourt 2002). Midwifery students, who are exposed to this way of working, even if only in theory, find the tensions between such models and the realities of tertiary midwifery services in Australia discouraging (NSW Health 2000). Any strategies to improve the education of midwives need to be mindful of the risks of retaining graduates exposed to models where they cannot fulfill the potential of the role and sphere of practice of the midwife (ACMI Victoria 1999). It has been suggested that placements for students in midwifery practices or models where midwives have caseloads and can foster an apprenticeship or mentorship relationship are optimal (ARM 1999). This model not only prepares graduates who can care for women in women-centred services, it enables students to identify and meet their own learning needs and promotes lifelong learning skills.

In reviewing midwifery in Australia when in her role as Professor of Midwifery at La Trobe University, Ulla Waldenstrom (1997) outlined developments, such as continuity of care models and birth centre care, which give cause for optimism about the future. She identified that the challenge is to change mainstream care in the public sector and that education needs to be expanded to facilitate these changes. Waldenstrom called for a review of midwifery education with international benchmarking, suggesting countries like New Zealand, the USA, Canada and the European Union. As an illustration she listed the clinical requirements for midwifery qualification of the 15 countries of the European Union where the recommended length of midwifery education for nurses is at least 18 months, full time. Australian midwifery education programs fall short of these standards in terms of both time allocated to education and the amount of clinical experience that is required.

Waldenstrom's recommendations (1996, 1997) are clearly an effort to address the notion that midwives should be competent to work autonomously from day one following graduation. This is the rhetoric of many Australian midwifery curriculum documents. However, the short length of courses when compared with other countries, the need for graduate midwifery programs and the notion of preparation for a 'beginning practitioner' (Glover 1999a) suggests that many Australian midwives may not be adequately prepared to work autonomously, without further education. This is paradoxical and concerning given that midwives are licensed to provide care on graduation

Australian midwives are seriously disadvantaged when they wish to work abroad and often have to complete further education and training, particularly in community midwifery (Leap 1999). In other comparable western countries, midwifery is being promoted as a public health strategy to address health inequalities (RCM 2000a, 2000b). Currently, the potential for students in Australian midwifery courses to gain experience in this role is limited with eleven courses not providing students with placements in any areas other than hospital wards. 'Community placements' in some other courses included 'a reproductive medicine unit', 'medical practitioner's rooms', 'a birth centre' or 'an elective in a rural hospital'. Clearly, any placement other than a hospital ward is being defined as 'community' making it hard for students to gain any understanding of primary health care principles in action. Instead, Australian midwives are being educated for an acute care role in the majority of courses and are not exposed to experiences that might foster an understanding of their potential role as primary care providers based in the community. Students need to learn to work with medical and allied health colleagues, and community services in a different role from that adopted as a midwife (or nurse) in a hospital team.

**The move from hospital based to university midwifery education**

Many of the concerns of the course coordinators in this study were associated with the move to university education. Arguably schools of nursing in universities have different outcomes and ongoing systems from those previously existing in schools of midwifery that were women's hospital or maternity unit based. Barclay (1986) showed that hospitable based programs were problematic in many ways, but they had more autonomy and focus than university programs set up in the last decade and more authority over course content and clinical experience. For teachers of nurses and midwives, the loss of identity with the health service and the difficulty in maintaining links and clinical

competence when trying to establish programs within a university setting have been well described by Barton (1998).

In Australia, the 'greatest debate' in a workshop to discuss the transfer of midwifery education to the university sector in 1992, related to the level of the award. Participants were unable to agree and some advocated strongly for nurses to be able to study to become midwives at both graduate diploma and masters level 'to allow the Registered Nurse a choice' (Glover 1992). In reporting on this meeting, Glover (p.9) questions whether the international definition of the midwife is appropriate 'for the midwife of today and the midwife of tomorrow' and suggests that the new university curricula 'must reflect the attitude, knowledge and skills of a beginning level midwifery practitioner'. This view is not reflected in the literature in other countries where the onus is on universities to educate midwives who can practise to the full role and sphere of practice of the midwife on graduation. In reporting on the same workshop, Sledzik (1992) identified that there was universal concern for a uniform approach to midwifery education from both a national and a global perspective, that adequate funding for midwifery programs needed to be secured, and that every effort should be made to ensure that theory and practice be integrated in the interest of competence in clinical practice.

In her survey of Australian midwifery education in universities in 1992, Hancock confirms that existing inconsistencies between states regarding registration criteria were exacerbated by the move to universities and the subsequent different levels of academic award. In a later opinion piece, Hancock (1996:7) sees the transfer of midwifery education to the higher education as a 'challenging but extremely worthwhile process'. She alludes to a process of 'grieving over the loss of hospital-based training' but suggests that comparisons are irrelevant given the potential for students to emerge as 'independent' practitioners, prepared to… 'meet with resolve the reality of midwifery as it can be and must be' (Hancock 1996:8).

This study raises debate about the experience of students who do not have a paid component in their midwifery practice placements with only six courses offering a paid model, 13 courses combining supernumerary and salaried experience and eight courses only offering students supernumerary clinical practice placements. Some midwifery educators have advocated for students to have supernumerary status in both the UK and Australia. This is in order to avoid situations described in studies by Begley (1999a, 1999b) in Ireland, by Chamberlain (1997) in the south of England and by Barclay (1985) in Australia. Students described seeing themselves as part of the workforce and believed that their educational needs were denied. Much of their learning took place by 'trial and error'. As in this study, the importance of mentorship or preceptorship in clinical areas was highlighted. However this study suggests that supernumerary students may be seriously disadvantaged compared to those with employed status. This could be seen, not only in terms of financial advantage, but also in terms of less clinical practice experience[10]. Australian midwifery students in supernumerary placements have fewer hours in practice areas and fewer opportunities to be immersed in the culture of midwifery. Course coordinators identified that many experience fragmented placements in different hospitals where they are not necessarily seen as 'part of the team' and are therefore marginalised. The nature of supernumerary placements also contributes to the lack of incentive on the part of hospitals to provide adequate numbers of placements for midwifery students.

This survey has demonstrated the fact that almost two-thirds of students in Australian midwifery education programs are engaged in part-time study and continue to work as nurses throughout their midwifery education. In our data, part time study appeared to be problematic, prolonging time to graduation and preventing immersion in the culture of maternity care. Given the time from commencement to completion, the linking of theoretical and practice learning seems serendipitous rather than planned or productive. Glover (1992, 1999) has advocated strongly for part-time midwifery education in Australia. Part-time study is not an option in three and four-year programs in Europe although various reports (ARM 1999, UKCC 1999) suggest that this should be considered in the future. In reviewing midwifery development in Canada, Tyson (2001) suggests that part-time study should be phased out, as it is inappropriate for primary care provider programs. She identifies that part-time study increases attrition and distraction of focus for students and that it takes many years to develop a midwifery identity. She questions the quality of clinical learning when there are long periods of time between introductory subjects and practice subjects and suggests that part-time study contributes to the problem of insufficient midwifery population, not to the solution.

[10] Supplementary data to follow in additional table

Part-time study and supernumerary status are directly related to the financial hardship of midwifery students according to the midwifery coordinators in this study. Midwifery in Australia is classified as a postgraduate qualification that builds on a nursing qualification therefore it often attracts full course fees. The financial constraints for nurses of undertaking midwifery education were described as also contributing to recruitment and attrition rates. Some supernumerary midwifery students are obliged to continue working as nurses throughout the period of undertaking midwifery education, some of them full time, fitting in midwifery placements whenever possible, a factor that is clearly stressful and mitigates against quality midwifery education and a sense of midwifery identity. The problems associated with students fitting full-time study and midwifery practice placements around continued full-time employment as nurses are alluded to by Glover et al (2001) and were identified as a major problem by midwifery course coordinators in this study. Students, who are employed and who are supported by health service employed educators do not have these problems.

## CONCLUSION

The AMAP Education survey demonstrate that concerns raised by Barclay in her 1986 analysis of midwifery education and practice have remained consistent and some may have been exacerbated by the move to university based education. Although there were problems while hospitals were in control of educating midwives, in many places they took ownership of midwifery education and invested heavily with skills and resources to ensure workforce and clinical competency requirements were met. This study raises serious concerns about the standards of midwifery education when international comparisons are made, particularly in terms of the length of courses, clinical practice requirements and the opportunities for students to engage with contemporary midwifery practice.

The midwifery course coordinators in this study articulated a clear understanding of the barriers affecting midwifery education and a significant commitment to articulate and engage in strategies to address these problems. Suggestions included increased collaboration between universities and service providers, addressing regulatory frameworks and the seamless integration of teaching by academics and clinicians. There was clear support for extending the length of programs to include a strong, funded clinical practice component with extended placements in midwifery models of care and the community. The funding of practice placements needs serious consideration and debate, particularly in relation to how this might be effected to include students of the new three year Bachelor of Midwifery programs.

As advocated by the midwifery regulatory authority in the UK, a full engagement and partnership should be developed between universities, health services and clinicians to resolve the ownership of, and responsibility for practice based education (UKCC 1999). This is an urgent need to address serious problems evident in the current system and concerns about the standards of current midwifery education in Australia.

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# IDENTIFYING THE MIDWIFERY PRACTICE COMPONENT OF AUSTRALIAN MIDWIFERY EDUCATION PROGRAMS. RESULTS OF THE AUSTRALIAN MIDWIFERY ACTION PROJECT (AMAP) EDUCATION SURVEY.

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## ABSTRACT

This paper is the first in a series of papers reporting on the findings of the AMAP Education Survey of the 17 universities providing a program for initial authorisation to practise midwifery. It concentrates on issues related to the practice component of courses[1]. Subsequent papers will present findings related to workforce issues and the barriers to effective midwifery education as identified by the midwifery course coordinators.

Serious concerns are raised about the standards of Australian midwifery education, particularly when international comparisons are made, in terms of the length of courses, clinical practice requirements and the opportunities for students to engage with contemporary midwifery practice across community and acute settings.

## INTRODUCTION

In 2001, researchers at the Centre for Family Health and Midwifery, University of Technology, Sydney undertook a survey of midwifery education as part of the Australian Midwifery Action Project (AMAP)[2]. The aim of this study was to describe the current position of midwifery education across Australia, as identified by the midwifery course coordinators in each university offering a program for initial authorisation to practise midwifery. Until recently, all midwifery education in Australia has been through postgraduate nursing courses. Data regarding the three-year Bachelor of Midwifery courses that started in four universities in 2002 and the double-degree (Nursing/Midwifery) course that commenced in one university in 2001 were not included in this survey.

In order to provide a national profile of midwifery education in Australia and develop recommendations, a range of issues were compared such as course demographics, prerequisites, minimum theory and practice hours of education, practice supervision and teaching processes. In line with the AMAP research questions, the study also explored the course coordinators' views of the barriers to effective midwifery education and strategies to overcome these barriers.

## BACKGROUND

The quality, nature or process of education of midwives has not been seriously studied in Australia for nearly two decades. During this period, programs have moved from hospital locations and teaching to universities. The hospital programs and their regulating framework of the 1970s and 1980s were recognised as highly problematic in terms of the quality of education (Barclay 1986) but, despite this, recent shifts in education have not been managed, monitored or evaluated.

Since Barclay's 1986 thesis, concerns regarding inconsistencies across states and territories and barriers to appropriate midwifery education and regulation have continued to dominate discussions (Hancock 1992, Barclay 1995, 1998, Barclay & Jones 1996, Bogossian 1998, Waldenstrom 1996,1997,

1 In terms of nomenclature, and in the interest of clarity and consistency, midwifery education programs are generally referred to as 'courses' throughout this paper since this was identified as the most common terminology in use when designing the questionnaire and during the telephone interviews. Similarly, the words 'clinical practice' are used here with recognition that the Australian college of Midwives has a commitment to use the words 'midwifery practice' to more accurately reflect the role of the midwife (ACMI Draft Standards for the accreditation of three year Bachelor of midwifery Programs).

2 The Australian Midwifery Action Project (AMAP) was funded by the Australian Commonwealth Government through the Australian Research Council as part of the then 'Strategic Partnerships with Industry research and Training' (SPIRT) program. A three-year project, AMAP was set up in April 1999 to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia and strategies to address these barriers. This included studying workforce, regulation, education, practice and service delivery issues across the country.

Leap 1999, Glover 1999, ACMI Victoria 1999, Tracy et al 2000, Brodie & Barclay 2001, Leap & Barclay 2002). Serious concerns have been expressed about Australian midwifery education when international comparisons are made, particularly in relation to preparing competent, confident midwives who are able to meet the challenges of contemporary midwifery practice and innovative changes in maternity service provision (Waldenstrom 1996, 1997, Leap 1999, Leap & Barclay 2002).

In New Zealand, Canada, the United Kingdom and other European countries, the dominant form of preparation for practice is through three and four-year midwifery courses rather than routes that require students to be nurses first. There is a move towards nurses having to undertake at least two years of full time study in these three and four year programs in order to gain sufficient experience of midwifery practice.

## METHODOLOGY

Using a structured questionnaire and primarily using telephone interviews, a survey was administered to all 27 universities offering a midwifery course leading to initial authorisation to practise as a midwife. Following ethics approval, the study commenced in May 2001 and data collection was completed in February 2002. The research was undertaken on behalf of AMAP by various researchers with different roles. The researcher who conducted the interviews collated and coded the data and presented it in a blended, de-identified format to the AMAP researchers for analysis.

## FINDINGS

Specific findings related to the clinical practice component of courses are represented here under relevant headings.

### Mode of study and length of course

A variety of modes of study were identified with the majority of courses [16] running internally although seven universities offered an external mode of study. Four other universities offered both modes of study. Six universities offered only part-time midwifery education courses, two offered only full time study and the rest offered both full time and part time study modes [Table 1- see page 16]. Based on enrolments in 2001, the number of students studying part time was 563 compared to 375 students enrolled in full time study.

Course coordinators were asked to describe the length of their courses based on full time study. This was problematic for the six who only offered part time courses; some of these gave estimates based on full time study, others gave the actual length of their part time courses. The length of courses for all those who offered a full time study mode included two academic semesters of approximately 13 -14 weeks each (n=21). Some course coordinators identified only the academic year as the length of their course. Others specified that the length of the course around these two semesters ranged from approximately nine months to 12 months (n=9) in order to include clinical practice placements [Table 1].

### Theory hours

There was considerable variation in the number of theory hours identified by course coordinators ranging from 174 to 2,160 hours with the majority (19) having less than 400 hours. Course coordinators who reported large theory hours in their courses appear to have based this figure on expectations of student initiated activity in courses offered externally.

### Clinical practice hours

The number of hours allocated to clinical practice also differed greatly between courses, as did the ratio of theory to practice hours [Table 1]. The range described by the course coordinators was between 500 and 1824 hours with the majority (16) less than 1000 hours. Table 1 identifies the variations in length of courses by mode, full time and part time status of students and the ratio of theory to practice components in courses.

**Table 1: Midwifery education programs by mode, full time/part time and supernumerary/employed status of students, length of program and numbers of clinical practice and theory hours as described by midwifery course coordinators**

| **Internal External mode** | **Fulltime** [f/t] **Part-time** [p/t] **Both** [f/t & p/t] **Supernumerary** S **Employed** E # | **Length of program** [based on f/t study unless stated otherwise] | **Clinical practice hours** | **Theory hours** |
|---|---|---|---|---|
| Internal | f/t S & E | Full 12 months | 1200 | 224 |
| Internal | Both S & E | Full 12 months | Supernumerary: 900 Employed: 1212 | 247 |
| Internal | Both S & E | Full 12 months | 1130 | 224 |
| Internal | Both E | Full 12 months | 1600 | 364 |
| Internal | Both S & E | Full 12 months | Supernumerary: 440 Employed only: 440 + 5 shifts per fortnight | 916 |
| Internal | Both S & E | Full 12 months | 832 | 252 |
| External | Both E | Full 12 months | 1824 | 954 |
| External | Both S & E | Full 12 months | 1032 | 1560 |
| Both | Both S | Full 12 months | 760 | 174 |
| Both | f/t S & E | 45 weeks | Supernumerary 640 + 2days wk salaried Employed: 925 | 222 |
| Both | Both S & E | 45 weeks | 1078 | 286 |
| Internal | Both S | 1 year * | 528 | 276 |
| Internal | Both E | I year: March to January | 1056 | 180 |
| both | Both S & E | Supernum.: 32wks Employed: 48 wks | Supernumerary: 1000 Employed: 1450 | 340 |
| External | Both S | 1 year: March - December | 800 | 600 |
| Internal | Both S & E | 1 academic year | 656 min Supernumerary: 2 days wk or equivvalent Employed: 5 shifts per fortnight | 312 |
| Internal | Both S | 1 academic year | 600 | 400 |
| External | Both S | 1 academic year | 600 | 312 |
| Both | both | 2 semesters March - Dec | 780 | 312 |
| External | Both S | 2 semesters March - Nov | 888 | Unable to say |
| Internal | Both S | 28 weeks | 500 | 320 |
| **Courses offered in part time mode only** | | | | |
| External | p/t S & E | Full 12 months | 800 | unanswered |
| Internal | p/t E | 12 months | 1660-1692 | 256 |
| Internal | p/t E | 3 semesters (p/t) | 1008 | 960 |
| Internal | p/t S (1st yr) E (2nd yr) | 42 weeks | 750-900 | 398 |
| Internal | p/t E | 4 semesters (p/t) | 1800 | 384 |
| External | p/t E | 64 weeks (p/t) | 800-1040 | 180 per unit - total 2,160 |

* In some cases it was not made clear whether 'a year' was an academic year of two 13 –14 week semesters or a full 12 months.

# Some courses offer a combination of supernumerary and employed experience. Where there are two separate models this is made clear in the clinical practice hours column.

## Clinical practice placements

Clinical practice placements occurred in different modes: weekly, block, yearly and sometimes a combination of these. Seven courses combined supernumerary and salaried experience, five courses offered either a supernumerary or employed option, eight offered supernumerary experience only and seven offered a salaried model only for clinical practice placements [Table 1]. Rates of pay for those who were in the salaried model varied and respondents identified this as an important issue that needs to be addressed. Students in nine courses were paid as RNs at their level of experience/service in nursing. Examples of other arrangements ranged from individual negotiations with employers to being paid at 'Level 1 RN' regardless of the student's experience in nursing .

Students undertaking supernumerary placements were allocated fewer clinical practice hours than those in models with a paid component [Table 1]. This factor was directly related to the financial burdens on students described by midwifery course coordinators and the fact that many students continued to work as nurses throughout their education in midwifery.

## Difficulties in organising placements

Course coordinators highlighted particular difficulties in arranging clinical placements. This restricted the number of places they were able to offer to students.

In the majority of courses students were particularly disadvantaged by not being able to access clinical placements that reflect contemporary maternity service developments, in particular, placements in the community and in midwifery models of care.

## Clinical support and supervision

Over half of the university staff involved in teaching midwifery are not involved in supervision and assessment in clinical areas. Course coordinators highlighted difficulties experienced by students in clinical practice placements that may contribute to attrition rates, both during their education and on graduation. These included the impact of a lack of 'ownership' by hospital staff of the need to provide support and supervision for students. The understaffing of areas where students were placed, stressful working environments and horizontal violence compounded these difficulties for students.

## Minimum clinical practice requirements to gain the award

The course coordinators generally referred the researcher to their local regulatory authority, usually referred to as the 'Nurses Board' regarding minimum clinical practice requirements. Those that offered a full explanation highlighted the differences that exist between state and territory standards in relation to the minimum practice requirements of midwifery education programs (Brodie & Barclay 2001).

## Types of facilities used by the students for clinical practice placements

Students were required to rotate through hospital areas and in some cases through different types of hospitals in order to meet the course accreditation requirements of the local nursing regulatory authority. As identified by Brodie and Barclay (2001), these requirements vary considerably from one state/territory to another. Rotation was most often driven by the need for students to have experience in tertiary referral centres and Level II nurseries. All but one respondent stated that they used tertiary level hospitals for midwifery clinical practice placements. With only a few exceptions, most courses also used regional or rural hospitals, some specifying that these facilities had to have a Level II nursery. In all but three courses, private hospitals were used for clinical placements, with four respondents clarifying that they only used private facilities to access experience for students in postnatal areas. Students placed in private hospitals needed to rotate into public hospitals in order to access sufficient experience of attending women labouring and giving birth.

One respondent identified that competition between universities for clinical practice placements in the same facilities forced students to rotate through different hospitals. In comparison, one respondent identified a system where it was compulsory for students to remain with the hospital to which they were assigned for the total duration of their midwifery education.

Some regulatory authorities did not require midwifery students to engage in any community based placements. Eleven courses did not enable

students to have placements in areas other than hospital wards. Table 2·identifies areas where students may have been able to gain 'community experience' in the 16 courses that offered this opportunity.

*Table 2. Summary of identified community placement areas used in midwifery programs (number of courses = 16)*

| |
|---|
| Elective time with independent midwife/midwives [6] |
| Maternal and Child Health Centres/Early Childhood Nurse [5] |
| Community midwifery program [3] |
| Women's Health Centre [3] |
| Family Planning/Sexual Health Centre [2] |
| Community Centre/ Support group [2] |
| Mother and Baby Unit/Residential Care for PND Unit [2] |
| Postnatal 'early discharge' program [1] |
| 'Urban Community Nurse' [1] |
| Overseas placement [1] |
| 'Community placement - e.g. Birth Centre' [1] |
| Reproductive Medicine Unit [1] |
| Medical Practitioner's Rooms [1] |
| Elective in rural hospital [1] |

Course coordinators identified difficulties in obtaining placements where students would gain experience in specific areas considered to address contemporary issues in midwifery practice as identified in Table 3. While the theory component of these practice areas was covered in courses, on the whole, placements in such areas were electives that the students had to organise and fund themselves. Course coordinators expressed frustration regarding the fact that placements were limited to care in hospitals within the confines of a one year program. Difficulties identified with placing students in rural and remote maternity services included the pressure to meet clinical requirements in areas where maternity service provision is occasional or low volume.

## Clinical practice placements: supervision and assessment

In most programs, responsibility for the organisation of clinical practice placements rested with the university. There were only five examples reported where hospitals and universities liaised closely in organising clinical practice placements. In some cases, before commencing their midwifery education program, students had to secure a placement with a hospital themselves and then have it approved by the university. In three instances the students were interviewed by the hospitals of their choice.

Arrangements for supervision and assessment varied considerably. The researchers had difficulties in identifying these arrangements with titles such as 'university staff', 'lecturer', 'mentor', 'preceptor', 'lecturer practitioner' 'clinical educator' and 'joint university/hospital appointee' being used interchangeably by some respondents to describe university and hospital staff positions.

*Table 3: Opportunities for clinical placements*

| Placement area | Placement offered | Elective option* | Not offered |
|---|---|---|---|
| Rural and remote maternity services | 13 | 3 | 11 |
| Aboriginal and Torres Strait Islander Health | 8 | 7 | 12 |
| Cultural diversity in midwifery care | 21 | 1 | 3 |
| Continuity of care models | 17 | 6 | 4 |
| Following women through | 23 | 2 | 2 |
| Birth centre care | 14 | 8 | 5 |
| Home birth | 4 | 12# | 11 |

** Elective option includes where course coordinators identified that it depends on whether the hospital the student is placed in offers this experience. It also includes situations where the student organises this experience (as opposed to the education provider).*

*# Placements with midwives providing home birth services were identified as rare, and almost always organised and funded by the student.*

### Difficulties experienced by students in clinical placements

Participants were asked to list the difficulties or problems experienced by their students on clinical placement. While it was recognised that not all students experienced problems the following nine themes were consistently identified as causing problems for students:

- Lack of support /supervision
- Horizontal violence
- Rostering issues
- Learning needs of the students are secondary to the hospitals needs
- Staffing issues
- Philosophy conflict
- Competing demands
- Placement difficulties.

These issues will be discussed fully in the second paper of this series, which identifies the barriers and strategies to midwifery education as described by the midwifery course coordinators.

## DISCUSSION

The AMAP Education Survey confirms concerns expressed by others regarding a lack of consistency in the duration or design of midwifery education programs, both nationally and within each separate state/territory (Hancock 1992, Chamberlain 1998, Glover 1999a, 1999b, Tracy et al 2000). An absence of midwifery specific regulation regarding standards for the accreditation of programs has led to these inconsistencies (Brodie & Barclay 2000).

In the last decade, new models of maternity care have been developed in Australia and overseas in response to changes in government policies and the identification of strategies to better meet the needs of childbearing women (Tracy et al 2000, NHMRC 1996). According to Page (1997:5), 'the basis of these reforms in all countries is the provision of appropriate education and preparation for modern day midwifery practice'. In Australia, as elsewhere, midwives are licensed and therefore must be prepared at a level that enables them to function as practitioners in their own right, without having to undertake further education or training. According to the international definition of a midwife (WHO 1966), graduates of midwifery education programs should be capable of taking responsibility for the total care of a woman (and her baby) throughout the woman's pregnancy, labour and birth, and the early postnatal period, referring to other health professionals only when complications arise. This role is described in many Australian midwifery curriculum documents. However, the short length of courses when compared with other countries, the identified need for graduate midwifery programs and the notion of preparation for a 'beginning practitioner' (Glover 1999a) suggest that many Australian midwives may not be adequately prepared to work autonomously, without further midwifery practice experience. This is paradoxical and concerning given that midwives are licensed to provide care in their own right following initial registration (Chamberlain 1998, Leap & Barclay 2002).

The AMAP education survey highlights inconsistencies in the minimum practice requirements of Australian midwifery education programs. Whilst most states require proof of achievement of both competencies and minimum practice requirements, in some states competency based assessment is the only requirement. The way this is implemented gives cause for concern. There is the potential for a situation where a preceptor could determine that a student is 'competent', even though the student has attended a minimal number of births. Glover et al (2001: 433) cite an example where a student could not get employment in her country hospital on completion of her midwifery education 'as she did not have enough experience as a midwife'.

In reviewing midwifery in Australia when in her role as Professor of Midwifery at La Trobe University, Ulla Waldenstrom (1997) outlined developments, such as continuity of care models and birth centre care, which give cause for optimism about the future. She identified that the challenge is to change mainstream care in the public sector and that education needs to be expanded to facilitate these changes. Waldenstrom suggested benchmarking standards with countries like New Zealand, the USA, Canada and the European Union, a process currently being employed by the Australian College of Midwives, Inc. As an illustration she listed the clinical requirements for midwifery qualification of the 15 countries of the European Union where the recommended length of midwifery education for nurses is at least 18 months, full time.

The maximum number of births that Australian midwifery students are required to participate in is twenty. Brodie and Barclay (2001: 106) point out that all current assessment regulations for midwifery fall well short of those required by the regulating bodies of other industrialised countries. They cite as an example the requirement in Europe for midwives to participate in at least 40 births and in Canada 60 births, before receiving registration. Brodie and Barclay (2001) also point out that in the United Kingdom, Canada and New Zealand, regulatory Boards use agreed national criteria to accredit, not only curricula, but also teachers, facilities and services. In these countries regulatory frameworks ensure that theory and practice are integrated in equal proportions in programs and that adequate staff to student ratios are maintained in clinical areas. Australian midwives are seriously disadvantaged when they wish to work abroad and often have to complete further education and training, particularly in community midwifery (Leap 1999).

In other comparable western countries, midwifery is being promoted as a public health strategy to address health inequalities (RCM 2000a, 2000b). Currently, the potential for students in Australian midwifery courses to gain experience in this role is limited with eleven courses not providing students with placements in any areas other than hospital wards. 'Community placements' in some other courses included 'a reproductive medicine unit', 'medical practitioner's rooms', 'a birth centre' or 'an elective in a rural hospital'. Clearly, any placement other than a hospital ward is being defined as 'community' making it hard for students to gain any understanding of primary health care principles in action. Instead, Australian midwives are being educated for an acute care role in the majority of courses and are not exposed to experiences that might foster an understanding of their potential role as primary care providers based in the community. Students need to learn to work with medical and allied health colleagues, and community services in a different role from that adopted as a midwife (or nurse) in a hospital team. Furthermore, the current indemnity insurance crisis has led to a situation where some midwifery students and their university lecturers are prohibited from practising in any areas other than in public hospitals under 'supervision'. This has serious implications for educating future practitioners to provide continuity of care to women across the interface between hospital and community settings.

Midwifery course coordinators lamented the lack of opportunities for students to participate in midwifery models, including birth centre care in hospitals. National and international research has demonstrated that where midwives are able to respond to the identified needs of women and provide a personal and continuous service through pregnancy, birth and the early weeks thereafter, they report an increased sense of satisfaction and autonomy (Sandall 1996, Stevens & McCourt 2002). Furthermore, the experience of working in such models of care may transform approaches and attitudes to practice (Brodie 1996, Homer et al 2000, Kenny et al 1994, McCourt & Page 1996, Page 1995, Rowley et al 1995, Waldenstrom and Turnbull 1998, Stevens & McCourt 2002). Midwifery students, who are exposed to this way of working, even if only in theory, find the tensions between such models and the realities of tertiary midwifery services in Australia discouraging (NSW Health 2000). Concerns about the mismatch between ideology and the realities of mainstream maternity service provision were expressed in this study. These concerns have been explored by Barnes (1997), who describes Australian midwifery students struggling to develop a 'woman centred' approach to care in the light of the increasing medicalisation of childbirth, in particular, rising epidural and caesarian section rates. Across the western world, the increasing use of technology in childbirth and escalating caesarean section rates limit the opportunity for students to learn about normal childbirth (Davies 1996, Hunt 2000).

This study raises debate about the experience of students who do not have a paid component in their midwifery practice placements. Some midwifery educators have advocated for students to have supernumerary status in order to avoid situations described in studies by Begley (1999a, 1999b) in Ireland, by Chamberlain (1997) in the south of England and by Barclay (1985) in Australia. In these studies, students described seeing themselves as part of the workforce and believed that their educational needs were denied. Much of their learning took place by 'trial and error'. As in this study, the importance of mentorship or preceptorship in clinical areas was highlighted. However this study suggests that supernumerary students may be seriously disadvantaged compared to those with employed status, not only in terms of financial discrimination, but also in terms of less clinical practice experience. Australian midwifery

students in supernumerary placements have fewer hours in practice areas and fewer opportunities to be immersed within a midwifery practice environment. Course coordinators identified that many experience fragmented placements in different hospitals where they are not necessarily seen as 'part of the team' and are therefore marginalised. The nature of supernumerary placements also contributes to the lack of incentive on the part of hospitals to provide adequate numbers of placements for midwifery students.

The AMAP Education survey has demonstrated that almost two-thirds of students in Australian midwifery education programs are engaged in part-time study and continue to work as nurses throughout their midwifery education. In our data, part time study appeared to be problematic, prolonging time to graduation and preventing genuine participation in maternity service provision. Given the time from commencement to completion, the linking of theoretical and practice learning seems serendipitous rather than planned or productive. Glover (1992, 1999a) has advocated strongly for part-time midwifery education in Australia. Part-time study is not an option in three and four-year programs in Europe although various reports (ARM 1999, UKCC 1999) suggest that this should be considered in the future. In reviewing midwifery development in Canada, Tyson (2001) suggests that part-time study should be phased out, as it is inappropriate for primary care provider programs. She identifies that part-time study increases attrition and distraction of focus for students and that it takes many years to develop a midwifery identity. She questions the quality of clinical learning when there are long periods of time between introductory subjects and practice subjects and suggests that part-time study contributes to the problem of insufficient midwifery workforce numbers.

According to the midwifery coordinators in this study, part-time study and supernumerary status are directly related to the financial hardship of midwifery students. Midwifery in Australia is classified as a postgraduate qualification that builds on a nursing qualification therefore it often attracts full course fees. The financial constraints for nurses of undertaking midwifery education were described as also contributing to recruitment and attrition rates. Some supernumerary midwifery students are obliged to continue working as nurses throughout the period of undertaking midwifery education. For some this means full time employment as a nurse and fitting in midwifery placements whenever possible. This factor is clearly stressful and militates against quality midwifery education and a sense of midwifery identity. The problems associated with students fitting full-time study and midwifery practice placements around continued full-time employment as nurses were alluded to by Glover et al (2001) and were identified as a major problem by midwifery course coordinators in this study. Students who are employed and who are supported by health service employed educators do not report these problems.

## CONCLUSION

This study raises serious concerns about the standards of midwifery education when international comparisons are made, particularly in terms of the length of courses, clinical practice requirements and the opportunities for students to engage with contemporary midwifery practice. It is crucial that full engagement and partnership be developed between universities, health services and clinicians to resolve the ownership of, and responsibility for, practice based education and move Australian midwifery education towards internationally recognised best practice.

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## NICKY LEAP. QUESTIONS FROM THE SENATE INQUIRY INTO NURSING 2001

### QUESTION 1

**What would be the specific educational benefits of such a course, as opposed to the current post-grad arrangements?**

The rationale for the introduction of an Australian Bachelor of Midwifery (BMid) has been explored in terms of the overall aim to increase the number of competent midwives and midwifery graduates in all areas of Australia (ACMI BMid Information Pack).

In all western countries, apart from the USA, three and four year programs in midwifery are seen as the most appropriate and cost effective way to educate midwives to be practitioners in their own right and to maintain high standards of midwifery education and practice. Midwifery education is not seen as a postgraduate extension of nursing education since the knowledge base, and educational requirements for practice are seen as separate. There is a trend towards nurses wishing to become midwives having to undertake at least two years of the same course and in many countries they have to undergo the full three or four years. The rationale for this is based in the international definition of the role and sphere of practice of the midwife

European countries such as France, Germany, Denmark, Belgium, Switzerland and the Netherlands have continued to develop three and four-year programs as the route of entry to midwifery ever since midwifery was regulated in those countries during the last century. In New Zealand, Ontario and the UK in the last ten years, three or four year programs have become the main route of entry to the midwifery profession. It is worth noting that, in the UK, the number of midwives registering to practise for the first time who were not nurses grew from less than 1% ten years ago to over 70% in 2001. The majority of universities now focus on three or four year programs as the most appropriate form of midwifery education. This could not have been predicted given the initial resistance to a resurgence of 'direct entry' programs that occurred with the move to university education.

Rigorous evaluation of three year programs in the UK concluded that the three-year route into midwifery is an effective preparation for contemporary midwifery practice. In spite of initial prejudices among some experienced midwife practitioners and teachers, the commitment and enthusiasm of these students towards woman-centred midwifery practice changed their views**.** Midwives were particularly impressed by students' knowledge and understanding of the theory underpinning practice, their reflective and questioning attitudes and wide reading and use of research. Evidence was abundant that pre-registration graduates could provide competent, normal, midwifery care to women on a one-to-one basis.

**Some of the arguments used by members of the Australian College of Midwives, Inc (ACMI 2002) to justify the rationale for the BMid in Australia were summarised thus:**

- International trends in midwifery education and evaluation of programs in the UK favour three and four year midwifery education programs;
- Addressing workforce shortages;

- The opportunity to develop national standards for midwifery education;
- Appropriate education to enable midwives to work in continuity of care models according to the international definition of the midwife;
- Currently Australian midwives must complete further studies and/or midwifery practice placements in order to register in other western countries;
- Expressed concerns over the standard of some graduates from midwifery education programs by employers;
- Many students are only experiencing fragmented midwifery practice in their education and are not equipped to work according to the international definition of a midwife;
- Each state and territory has its own midwifery course accreditation processes through Nurses Regulatory Boards. Graduates emerge from midwifery programs with different qualifications, having met different standards;
- Depending on the state or territory, graduates may emerge from programs having attended 20 births, 10 births or fewer than 5 births if the assessment is purely competency based without any repeated practice requirements (In other countries students need to have been the primary attendant for at least 40 births);
- Midwifery education programs are accredited according to the individual regulatory authority's nursing standards and often midwifery is invisible in the regulation. For example, courses may have to demonstrate that they have a 'nursing focus' and that 'qualified nurses' teach them;
- Courses are seen to build on a nursing degree and therefore midwives tend to graduate with a Graduate Diploma or Masters degree, with one state offering a Bachelor program (two-years part-time);
- In many cases, students study midwifery part-time while they work full-time as nurses. Some have clinical placements where they are supernumerary which they fit into annual leave over a prolonged period of time. Clearly this is unsatisfactory in terms of acquiring skills and competency;
- High attrition rates for nurses in midwifery;
- Addressing the current financial pressures associated with midwifery education. All undergraduate health courses are HECS based;
- There is no longer a trend for the 'double certificate' nurse/Sister and this has impacted on the number of people entering midwifery;
- Addressing regulatory inconsistencies between states and territories. The regulatory process of 'mutual recognition' across states and territories makes this an imperative. Employers need to know that they can rely on the standards of practice and competency of all graduates, regardless of the state or territory in which they qualified;

**ACMI Standards for the Australian Bachelor of Midwifery**

The ACMI has coordinated a taskforce to develop national standards for the accreditation of the three-year BMid and hopes to work collaboratively with the registering authorities in the future regarding the implementation and evaluation of these standards.

The ACMI BMid Taskforce has a commitment to ensuring international compatibility so that graduates of the Australian BMid courses will be able to register to practise in other countries without having to undergo further training and education as they do now. There is awareness of the need to avoid a two-tier system of standards for midwifery courses where nurses engaging midwifery education are disadvantaged by a shorter course and reduced clinical requirements and placements. All midwifery graduates should emerge from their programs of education having achieved the same level of competency and the same repeated practice requirements regardless of their route of entry to the profession. Currently, graduates from one year postgraduate courses for nurses would not be able to meet the proposed *ACMI Standards for the Accreditation of the Australian three year Bachelor of MidwiferyPrograms*, particularly in terms of the required practice component of courses leading to authority to practise midwifery.

The introduction of the Bachelor of Midwifery programs in Australia may play a major role in the development of the potential for midwifery to gain control of all processes associated with designing its own education, practice and regulation in the interest of improvements in maternity services. The experience in New Zealand, Canada and Europe has demonstrated that where midwives are educated to work to the full potential of their role they have every opportunity to negotiate and develop new systems of care. The *ACMI Standards for the Accreditation of three year Bachelor of Midwifery Programs* should enable the education of midwives who can respond to women's needs and who will be able to follow women through their experience of pregnancy, childbirth and the early weeks following birth, regardless of where and how the birth occurs. This will always mean being able to collaborate well with other health professionals in order to optimise quality services for women and their families around childbirth.

**QUESTION 2**

**Is the concern related to the current standard of courses, lack of alternative models or other factors?**

A review of midwifery education, commissioned by the Department of Education, Science and Training (DEST) and the Department of Health and Aged Care (DHAC) as part of their *National Review of Nursing Education*, identified serious concerns regarding the current standard of courses (Leap & Barclay 2002).

The reviewers undertook a comprehensive literature search on midwifery education in Australia, The United Kingdom, Canada, New Zealand, the Netherlands and the United States of America. The review drew on databases, policy documents, research and other resources, in collaboration and with assistance from national and international experts. Additional information was incorporated from a survey of midwifery education in Australia funded by the Australian Research Council as part of the Australian Midwifery Action Project (AMAP). This research was conducted in partnership with key stakeholders, from government and the profession. An analysis of the development of the three year Bachelor of Midwifery was also included to demonstrate how acceptable national standards and consensus can be established, despite the absence of this in the current education of midwives.

An extract from the Executive Summary of this review is reproduced here to explain the identified concerns related to midwifery education in Australia:

> (Leap & Barclay 2002: *Midwifery Education: Literature Review and Additional Material. Final Report.* Prepared for National Review of Nursing Education. Department of Education, Science and Training & Department of Health and Aged Care. Canberra.)

**Findings**

This Review… draws on new research that confirms serious inconsistencies across states and territories in the education and regulation of Australian midwifery. There has been a lack of national professional leadership and absence of high quality accountability structures leading to the current situation.
We report, with evidence substantiating this, serious concerns about the standard of midwifery education in Australia, particularly when comparisons are made with midwifery education in other western countries.

The Review demonstrates that concerns raised in a 1985 analysis of midwifery education (Barclay 1985) have remained consistent and been exacerbated by the move to university based education. The reviewers suggest that although there were significant problems with hospital control of education, in particular the theoretical aspect of programs, in many places health industry 'ownership' of midwifery education meant students achieved workforce and clinical competency requirements.

University 'ownership' has not been sufficiently tempered by jurisdictional regulations governing accreditation nor a sufficiently strong professional association until recently. This has meant a decline in the clinical experience and competency of students over all.

Information collected for this review leads the authors to conclude that the lack of accountability and inadequate accreditation mechanisms have led to the following situation:

- Industry has lost its influence in relation to the numbers of midwives being educated and clinical practice requirements and frequently feels disempowered and dissatisfied as a consequence. There are notable exceptions to this where industry has remained highly influential and provides a strong clinical presence and teaching in university programs;
- There are problems associated with the supernumerary and part time status of students that appear, in many cases, to exacerbate the separation of the program from industry involvement or investment as well as creating economic problems for students;
- The midwifery professional body has had little influence on midwifery education standards;
- There has been no understanding of the consequences of policy changes regarding the funding of midwifery education or any nationally coherent response to these changes;
- Midwifery educators tend to be isolated from practice areas within universities rather than strongly clinically located and 'grounded'. Most work as individuals, and are not sufficiently powerful to 'override' school of nursing priorities in programs or claims on resources. They have lacked strong support from either a

national association or strong accreditation requirements from Nurses Boards that could have ameliorated this situation.

**Problems of Leadership**

An absence of midwifery specific regulation and informed, strong and cohesive representation has led to inconsistencies in the accreditation of programs and standards across Australia. There are currently no nationally agreed and applied standards of midwifery education applied in accreditation mechanisms, although the Australian College of Midwives Inc (ACMI) has recently developed these in relation to the proposed 3-year Bachelor of Midwifery (BMid). The ACMI has brought together expert opinion and facilitated consensus from experienced educators for the first time and the results are under consideration across the country.

Strategies for midwifery educational reform in Australia are originating from the professional body currently (described above), but there are no national or State and Territory jurisdictional commitments, incentives or requirements to comply with these.

The introduction of the post graduate fee for specialist 'nursing' courses have created problems in attracting students into full fee paying programs and financial burdens for midwifery students. These have been exacerbated in supernumerary and part-time courses.

Insufficient professional and industry influence over courses in Australia and the concerns that some programs do not prepare competent or employable graduates appear born out by the very limited clinical experience offered by some programs. Competency standards and assessment are not nationally agreed or applied despite 'mutual recognition' operating across state borders.

There has been insufficient quality control and monitoring of the transfer of midwifery education to universities by the profession and regulating authorities. Regulation for midwifery education and practice is of variable quality and not consistent across the nation.

Nursing education priorities have taken precedence in educational institutions and regulating bodies, therefore decisions and leadership have not necessarily reflected the professional midwifery or maternity services needs as well as is required.

**Workforce**

Workforce shortage and mal-distribution of age groups in the Australian midwifery workforce are not being addressed by current course enrolments, though the high demand for the BMid has the potential to make a significant improvement to this situation.

Attrition rates in some postgraduate programs for nurses wishing to become midwives are excessive and enrolments are low suggesting problems of quality and credibility in these programs.

There are problems addressing the needs of rural Australia, especially Indigenous communities, within current courses. There are some important exceptions in rural areas, and models that are working well.

Retention strategies for graduates have not been addressed nationally, coherently or at all in some states, therefore they are not well designed or developed to meet Australia's maternity services.

The continuing education of midwives in Australia remains ad hoc and there are no national policies, incentives or requirements for maintenance by organisations, such as employers, some regulators or individuals.

**Education and Learning**

Midwifery teaching and learning frameworks have been poorly developed overall, however there are some promising examples of *midwifery* approaches to evidence based teaching and the flexible delivery of midwifery education. Issues of quality control need careful monitoring

**Lessons for policy identified in this Review**

- The serious implications involved in imposing postgraduate fees for nurses on entry to a new discipline;
- Difficulties establishing national standards associated with the jurisdictional independence of Boards in each State and Territory and no commitment to consistency in the accreditation of midwifery education programs nationally;
- The need for policy support for the 'direct entry' option to achieve the same qualification as postgraduate courses for nurses in a shorter time through the Australian Bachelor of Midwifery;
- Problems of recruitment and retention issues, that are international as well as local, and require national strategies;
- Declining international compatibility of midwifery education in a climate of international 'mutual recognition' policies;
- Health services have abdicated or had withdrawn their responsibility for student learning (e.g. providing student placements and clinical teaching in a range of midwifery models as well as in risk-associated maternity care, to ensure the range of skills of graduates). There is a need to support/initiate joint education and health service involvement in programs, for example in setting up joint clinical and teaching posts and education for preceptors/facilitators and clinical mentors for students;
- Active support and incentives are required for rural students and Aboriginal and Torres Strait Islander students to enter programs that meet their learning and cultural requirements;
- There is an urgent need to specifically regulate midwifery education and practice and for the development and application of national standards for midwifery education and practice within jurisdictions;
- National research is needed to investigate, monitor and evaluate the introduction of the Australian Bachelor of Midwifery and to compare and standardise outcomes with a strengthened and improved *national* approach to include standards for the midwifery education of nurses.

In specific terms this report has highlighted the following issues:

- Workforce shortage and mal-distribution of age groups in Australian midwifery with workforce needs not being addressed by current courses enrolments;
- Problems of attracting students into full fee paying programs and financial burdens for midwifery students that are exacerbated in supernumerary courses;
- Inconsistencies within midwifery course accreditation requirements and regulation of practice in Australia;

- Lack of nationally agreed and applied standards of midwifery education;
- Insufficient professional and industry influence over courses and student selection procedures in Australia;
- Industry concerns that some programs do not prepare competent or employable graduates;
- Increasing incompatibility of Australian midwifery education with international standards;
- Attrition rates in some programs and areas are excessive and enrolments are low suggesting problems of quality and credibility in these programs;
- Insufficient control and monitoring of the transfer of midwifery education to universities by professional and regulating authorities;
- Problems addressing the needs of rural Australia, especially Indigenous communities within current courses, though there are some important exceptions;
- Retention strategies for graduates are not well designed or developed;
- Strategies for midwifery educational reform in Australia are originating from the professional body currently, but there are no national or State and Territory commitments or incentives to comply with this initiative;
- The continuing education of midwives in Australia remains ad hoc and there are no incentives or requirements for maintenance by organisations or individuals;
- There are promising examples of flexible delivery of midwifery education, but issues of quality control need careful monitoring;
- Competency standards and assessment standards are not nationally agreed or applied;
- Regulation for midwifery education and practice is of variable quality and not consistent;
- Nursing educational priorities have taken precedence in educational institutions and regulating bodies, therefore decisions and leadership have not necessarily reflected the professional midwifery or industry needs as well as is required.

(Leap & Barclay 2002: *Midwifery Education: Literature Review and Additional Material. Final Report.* Prepared for National Review of Nursing Education. Department of Education, Science and Training & Department of Health and Aged Care. Canberra.)

**QUESTION 3**

**Would you have any concerns that the reduction in years of training – from the current 5 years to 3 years – may lead to a reduction in the educational standards of midwives?**

This question presupposes that midwifery education includes:

- Three years of education in *nursing*
- Plus a year of practice in *nursing*
- Plus **one year** of postgraduate education in midwifery.

Although it is recognized that there are some limited skills and knowledge, useful to midwives, that can be obtained in *nursing* education and practice contexts, four years of experience in *nursing* plus a one year midwifery education program is not considered appropriate or adequate in other western countries where midwifery is seen as a discreet discipline, requiring a separate knowledge base. Unlike nurses, from initial qualification, midwives are recognised as practitioners in their own right. They may take

on total responsibility for healthy women and their newborn babies, without referring to medical practitioners unless there are complications.

In essence, nurses entering midwifery education in Australia can only experience a **one year** program to develop knowledge and exposure to midwifery practice compared to the **three or four years** that is considered necessary in many other comparable countries that do not see any links between nursing and midwifery programs.
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# Contemporary issues in Australian midwifery regulation

PAT BRODIE AND LESLEY BARCLAY

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* The Australian Midwifery Action Project (AMAP) is a three year study funded by the Australian Research Council and five industry partners. It was set up to identify and investigate barriers to midwifery within the provision of mainstream maternity services.

## Abstract

*This paper reports on research that examined the Nurses' Acts, regulations and current policies of each state and territory in Australia, in order to determine their adequacy in regulating the education and practice of midwifery. This is part of a three-year study (Australian Midwifery Action Project) set up to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia. Through an in-depth examination and comparison of key factors in the various statutes, the paper identifies their effect on contemporary midwifery roles and practices.*

*The work assessed whether the current regulatory system that subsumes midwifery into nursing is adequate in protecting the public appropriately and ensuring that minimum professional standards are met. This is of particular importance in Australia, where many maternity health care services are seeking to maximise midwives' contributions through the development of new models of care that increase midwives' autonomy and level of accountability.*

*A lack of consistency and evidence of discrepancies in the standards of midwifery education and practice regulation nationally are identified. When these are considered alongside the planned development of a three-year Bachelor of Midwifery, due to be introduced into Australia in mid-2002, there exists an urgent need for regulatory change. The need is also identified for appropriate national midwifery competency standards that meet consumer, employer and practitioner expectations, which can be used to guide state and territory regulations.*

*We argue the importance of a need for change in the view and legal positioning of the Australian Nursing Council and all Nurses Boards regarding the identification of midwifery as distinct from nursing, and substantiate it with a rationale for a national and consistent approach to midwifery regulation.*

## Introduction

It is timely to review the current system of midwifery regulation in Australia. In the last decade the organisation and context for the provision of maternity services has changed considerably.

Major shifts in government policy direction and reforms across maternity care services have occurred as a response to community demand and evidence of the safety and satisfaction with midwifery care (Homer et al. 2001; Kenny et al. 1994; Rowley et al. 1995). As a result, new models of care have emerged that require midwives to work in more flexible arrangements rather than the 'shifts' of the traditional eight-hour salaried employee.

New working conditions are emerging reflecting increased autonomy and self regulation of practice and standards (Department of Human Services 1999a; Department of Human Services 1999b; NHMRC 1996; NHMRC 1998; NSW Health Department 1989; NSW Health Department 2000; Victorian Department of

Health 1990). Compounding this internationally and nationally is the increasing prominence of undergraduate (non-nursing) programs in midwifery.

The United Kingdom (UK) now prepares the majority of midwives in comprehensive three-year and four-year programs (Fraser 2000). Other Western countries such as the Netherlands, France, Denmark, Germany and Sweden have always educated midwives through three and four-year programs. These countries report some of the best standards of practice and clinical outcomes in maternity care in the world (Campbell & Macfarlane 1994; McKay 1993; Tew 1990).

In New Zealand, all one-year midwifery programs have now ceased. Nurses themselves who considered that their one-year program was inadequate in comparison to the three-year midwifery program initiated this action (Personal communication, Pairman 2000). With an increasing emphasis world-wide on the use of evidence to inform practice, policy making and the organisation of services, the midwifery profession is challenged to change and develop, in order to meet the needs of the community, governments and employers.

The changes described above have the potential to significantly affect the way midwifery is regulated and organised in Australia. Since World War ll, midwifery has been predominantly based in acute care hospitals and within nursing models of organisation and management (Barclay 1986). Changes to practice, education and regulation will be necessary if contemporary Australian midwives are to meet these demands and if the standard of midwifery care offered to Australian women is to be comparable to other Western countries.

The necessity for rethinking the regulation of practice to keep pace with changes in the organisation of health care and the role and scope of practice of the midwifery profession is obvious. This paper provides an overview of the regulation of midwifery in Australia. It examines and compares key factors in the various state and territory Acts, to identify their effect on contemporary midwifery roles and practices. The work aims to test whether subsuming midwifery into nursing within the current regulatory system protects the public and ensures professional standards are met. This is of particular importance in the current health care climate that is seeking to maximise midwives' contributions and expand their autonomy and level of accountability (Commonwealth Department of Health and Aged Care 1999; NHMRC 1996; NHMRC 1998; NSW Health Department 2000). A regulatory framework is required that clearly identifies midwifery and enables the necessary health services reform to occur in a manner that both protects the public and enables the appropriate education of the profession.

## Background

In Australia, midwives and childbearing women have historically not had a strong voice in planning and implementing regulatory systems and public health policy (Barclay 1984; Barclay 1985a; Barclay 1995; Summers 1998). Midwifery has been subsumed into nursing since regulatory systems for nurses were set up in the 1920s (Bogossian 1998; Summers 1998). With few exceptions, nursing leaders have been required or have chosen to represent both nursing and midwifery and the interests of nursing have been privileged. Midwifery has been seen post World War II, as just one of the many specialities of nursing, similar to for example mental health, paediatrics or aged care (Barclay 1986). This has meant that, despite all the evidence linking improved maternal and infant health outcomes with autonomous midwifery practice (Department of Health Expert Maternity Group. 1993; Katz-Rothman 1991; World Health Organisation 1996), midwifery has declined as a separate profession since the 1920s and 1930s. Enactment of single nursing registers within some state and territory Nurses Acts over the past decade has further compounded this issue. Through the various Nurses Acts and regulations, reviewed in the 1980's (Barclay 1985b), in the 1990s (Bogossian 1998) and again for this paper, midwifery has remained 'invisible' in a legal sense in Australia.

In contrast, in many western countries midwifery has always been recognised as a discipline distinct from nursing. Recently, some countries such as the United Kingdom and Ireland have reasserted the value of this distinction (UKCC 1998; Government of Ireland 1998). The current UK registration statute is titled the *'Nurses, Midwives & Health Visitors' Act (1998)*, which clearly recognises the distinction between these disciplines. A recent major review of this Act has highlighted the need to:

"ensure that the public protection afforded by the Act is effective while not stifling developments in health care" (UK Health Department and JM Consultancy Ltd 1998), p6).

The midwifery profession in Australia is currently questioning inconsistencies and apparent failures of the current regulatory and education systems for midwives (Summers 1998; Tracy, Barclay, & Brodie 2000; Waldenstrom 1996). This follows serious concerns identified more than fifteen years ago (Barclay 1984; Barclay 1995) which, while continuing to be raised through a number of different forums (NSW Health Department 1989), have received insufficient attention from regulatory bodies, funders and policy makers (Commonwealth Department of Health and Aged Care 1999; NSW Health Department 1989; NSW Health Department 1998; NSW Health Department 2000; NSW Health Department 2000). These concerns are exacerbated by, and should be considered in the light of, the move from hospital-based midwifery education to the tertiary sector and an absence of any formal evaluation or analysis of the impact of this move on standards of care and practice.

The consequences of changing service delivery models and the shifting of health care from hospitals to the community, a common trend in many western countries, alter the role, scope of practice and education of midwives. Australia's high standard of maternity care assumes the presence of qualified midwives. They offer safety and support for women in childbirth and the postnatal period in collaboration with medical colleagues, and increasingly as primary providers of maternity care in their own right (NHMRC 1996; Australian Medical Workforce Advisory Committee 1998).

Concerns about the educational standards of midwives are also associated with global changes and reforms in the way midwifery is regulated (Department of Health UK 1998; Jowitt 2000; Lilford 1993; Norman 1998; Rogers & Ryan 2001; UK Health Department and JM Consultancy Ltd 1998). The highest standards should be employed in the regulation of both midwifery and nursing in order to optimise protection of the public and to promote and maintain public trust and confidence with the professions. Across Australia, the regulatory Boards (In this paper Nurses' 'Boards' includes the Queensland Nursing Council) of each state and territory regularly review their systems and processes in order to meet their objects. Boards have a key responsibility to communicate to consumers the competency standards that they can expect of nurses and midwives (Australian Nursing Council Inc. 2001).

Through these endeavours the Australian Nurses' Boards aim to promote consumer involvement, high professional standards, greater protection for the public and better regulatory practice. There are however profound differences in the way this is done. The results and comparability of current processes in a climate of mutual recognition is problematic. It is timely that a more modern regulatory framework that encompasses self-regulation, personal accountability and agreed national standards be developed.

## Aim

The aim of the research reported in this paper was to analyse the Nurses' Acts, regulations and current policies of each state and territory to determine their adequacy in regulating the education and practice of midwifery in Australia.

## Method

Each of the eight statutes were obtained electronically and downloaded from The Australasian Legal Information database (AustLII). These were analysed for similarities and consistency in structure, format, content and relevance. An overview of the current legislation that regulates midwifery in all states and territories was constructed from this data.

A systematic content analysis that included the search for the basic attributes and common features found in most forms of professional regulation was conducted.

Themes, contrasts, gaps and inconsistencies were highlighted and compared across each of the statutes. Diversity within these basic attributes and their relative importance to each other was analysed and reported only when this appears to have negative consequences or outcome. A comparison of midwifery regulation documents from the United Kingdom, Europe and New Zealand, as well as some of the recent published literature, was made to verify assumptions and contrast Australia with international standards of midwifery education and practice.

The authors consulted with a nurse-lawyer, which enabled a number of inconsistencies and anomalies to be identified. This resulted in the drawing of a number of conclusions about the Acts and regulations as they currently exist including certain limitations and concerns.

Two key questions were asked of the regulations:

- What are the current laws, regulations and policies, which govern midwifery practice and education and how do they compare between states and internationally?
- What are the features of the current system of regulation of education, practice and competency of the midwifery profession?

The authors hypothesised that, within the current system of nursing regulation through the state and territory Boards, there is confusion about the role of the midwife with a lack of consistency that challenges the legitimacy of the current Acts and their capacity to protect the public.

# Results

## Midwifery education regulation

Currently there is wide discrepancy between midwifery educational programs across the country with concerns that current midwifery programs in Australia do not meet recognised international competency standards for midwives (Leap 1999a) (AMAP unpublished data, July 2001) or even nationally agreed baselines. This is confirmed by examination of state and territory regulations with regard to approval of courses and institutions. For example, in New South Wales, all students of midwifery are required to meet the particular competencies of a midwife as set out by the Board plus complete a list of clinical requirements including twenty births, twenty abdominal palpations and ten vaginal examinations (Nurses Registration Board of NSW 2000). In some states however, such as South Australia, Western Australia and Queensland competency based assessment of students has completely replaced a system of minimum clinical requirements for qualification. In South Australia, student midwives are assessed through a 'competency- based approach' that does not stipulate a specific number of clinical requirements, hours or shifts in a particular area (Glover, James, & Byrne 2001). The Nurses Board of Northern Territory require midwifery students to master three skills, chosen from a list of six or eight, in each of four different clinical areas (Nurses Board of Northern Territory 1989). Unpublished data reports that some midwives have been able to register after completing as few as five births (AMAP data, unpublished 2001). One recent publication reports how graduates educated through this 'competency based approach' may not be employable as midwives in the same small country hospital where they completed their clinical placement because they are not considered to have enough experience (Glover, James, & Byrne 2001).

There is a wide range of clinical practice requirements, which are developed locally by each Board through 'consultative' processes. These vary and they reflect the priorities and expectations of the individual group, rather than any agreed national formula or standard for consultation and review. Large differences in the number of theoretical and clinical hours of programs are also compounded by the variability that exists in the amount and type of clinical experience available to students. In addition, in the absence of national standards, labour force shortages make these local processes vulnerable to manipulation, with potential to undermine practice standards even further. The Australian Midwifery Action Project (AMAP) is conducting a survey of all universities currently offering midwifery education leading to authority to practice. This research will highlight the lack of comparability of current midwifery curricula, including number of clinical and theoretical hours, assessment of competency, duration of course and nomenclature of awards.

To date, the Australian nurses boards have not been able to agree on universal adoption of the Australian College of Midwives Competency Standards for Midwives (Australian College of Midwives Inc. 1998). By late 2001, three out of eight Boards (New South Wales, Western Australia and Northern Territory) had not adopted the midwifery competencies specifically developed by the profession (Personal communication, ACMI, 2001). This is problematic though not surprising given the variable composition of the Boards, the lack of consistency with regard to midwifery representation and the wide variation in standards of regulation. Table 1 shows how the various Boards are constituted with only two states, NSW and WA specifically requiring within the Act that a midwife actually be a member of the Nurses Board (Nurses Board of Western Australia 1992; Nurses Registration Board of NSW 1991).

**Table 1: Composition and structure of the eight Nurses Boards and Councils including level of midwifery representation**

| State/Territory | Constitution of the Board | Chairperson of the Board |
|---|---|---|
| Australian Capital Territory | Chairperson + 4 other members not more than 2 to be EN appointed + 4 members elected in accordance with Health Professionals Boards (Elections) Act. Must be RN or EN entitled to practise as such for 3 years in any State or Territory prior to this time | Must be RN as does deputy |
| New South Wales | 13 members appointed by Governor: 3 elected RNs; 1 EN; 1 RN authorised to practise midwifery. 1 RN from NSW Nurse's Association; 1 RN from NSW College of Nursing; 1 RN from Minister of Health; 1 RN educator of nurses, nominated jointly by Minister School Ed & Youth Affairs and Minister of Further education, Training and Employment; 1 RN Psych nurse, nominated by Minister; 1 barrister or solicitor. 2 consumers | Not specified |
| Northern Territory | 8 members: RN responsible to Chief MO for nursing services in Territory; Person in charge of medical services at Darwin Hospital; RN in charge of nursing at Alice Springs Hospital; RN in charge of nursing services at Darwin Hospital; 4 persons appointed - 1 RN, 1 qualified practising nurse educator; 1 RN and 1 EN nominated by ANF | RN responsible to the Chief Medical Officer for nursing services in Territory |
| Queensland | 13 members: 5 RNs; 5 nurses chosen from panel of names submitted by associations accepted by Minister as representatives of nurses; 1 consumer; 1 lawyer; Executive officer of the council | Governor in Council appoints member of the board who is not an officer of the public service |
| South Australia | 11 members:1 RN nominated by Minister - presiding member; 5 RN or EN elected; 1 Medical practitioner; 1 lawyer; 3 people nominated by Minister who are not nurses, lawyers or doctors, at least one woman and one man | Appointed by Minister |
| Victoria | 12 members; 9 must be RN - 2 must be registered under Division 2; 1 lawyer; 2 non nurses | President and Deputy appointed by the Governor in council, must be RNs |
| Western Australia | 12 members appointed by the Minister: 2 ANF[1] midwife[2]; 1 Psych nurse[3]; 1 RCNA WA[4]; 2 EN[5]; 1TAFE[6]; 1 Curtin[7]; 1 Edith Cowan[8]; 1 Minister Consumer Affairs[9]; All members to be natural persons and have 3 years standing in practice | Presiding member appointed from members by Minister and after consultation with the Board |
| Tasmania | 7 members nominated by the Minister and appointed by the Governor: 5 practising nurses with ability to fulfil the Board's objectives; 2 persons who are not nurses who represent the interests of persons who use the services of nurses. | A practising nurse, appointed by the governor |

## Explanations for Table 1:

1. Australian Nursing Federation nominates two representatives who are registered on Division I of the register
2. The Australian College of Midwives Incorporated (WA Branch) nominate a person with knowledge of and experience in midwifery and who is registered on Division 1 of the Register.
3. The Psychiatric Nurses Association nominate one representative
4. Royal College of Nursing WA Chapter nominate one representative with knowledge and experience in nursing administration

5. The Federated Miscellaneous Workers Union of Australia nominates two representatives who are enrolled nurses
6. The Executive Director of TAFE nominate one representative who has knowledge and experience teaching nurses to be registered under Division 2
7. The Chancellor of Curtin University nominates one representative who teaches nursing at that university
8. The Council of Edith Cowan University nominates one representative who teaches nursing at that university
9. Minister, Consumer Affairs nominates one person who has consumer representation experience

In a climate of maternity services reform with increasing prominence of midwifery, it is inappropriate for Boards to continue to state that the conceptual framework and course philosophy for midwifery education programs must have a 'nursing focus' (Nurses Board of South Australia 1997; Nurses Board of Western Australia 1993). Similarly, regulations that require curricula based on 'nursing theory and practice', with teachers of programs having a 'nursing background' (Queensland Nursing Council 1993; Nurses Board of South Australia 1997), are out of step with contemporary practice. Quite apart from the impact on content and syllabus, this terminology alone, emphasises inconsistencies of Australian regulation with midwifery education nationally and internationally.

This approach does not ensure that the community is either protected through practice or receive optimally educated practitioners. It also disadvantages both students and universities in terms of potential international exchanges, recruitment of high quality academics and the marketing of courses in other countries. There are also concerns about how these issues contribute to a situation where Australian midwives, unlike nurses or medical practitioners, routinely have to undertake further education if they wish to practise in other countries (Leap 1999b).

Reviews of midwifery educational and clinical facilities conducted by the Boards are not required by all states. Where they are required (Nurses Board of Western Australia 1993; Nurses Registration Board of NSW 1997), there is no consistency in requirements for how these visits are to be performed or the qualifications of persons performing them. There is no evidence of any formal link or expected compliance between states and territories. This is in spite of the Australian Nursing Council Incorporated (ANCI) stating that one it's key functions is to:

> *'lead a national approach with State and Territory nurse regulatory authorities in evolving standards for statutory nurse regulation which are flexible, effective and responsive to health care requirements of the Australian population'*
> (Australian Nursing Council Inc. 2001).

In contrast, in the United Kingdom, Canada and New Zealand regulatory Boards use agreed national criteria to accredit curricula as well as teachers, facilities and services. Robust validation of standards of midwifery education and midwifery practice settings, determined by the profession, in consultation with consumers and in keeping with changes and new directions in health service delivery, is expected (English National Board for Nursing 1998; Nursing Council of New Zealand 1996; Ontario College of Midwives 2001). In addition in the UK, health care facilities are required to demonstrate evidence of 'keeping up to date with government policy direction and principles of care' (English National Board for Nursing 1998).

Concerns with the quality of the current Australian midwifery workforce have recently been articulated (Tracy, Barclay, & Brodie 2000; Waldenstrom 1996) and these will require addressing within the regulations as well as by education and service providers as well as professional bodies1. All current assessment regulations for midwifery fall well short of those required by the regulating bodies of other industrialised countries, for example the requirement in Europe for midwives to participate in at least 40 births (European Community Midwives Directives 1980) and in Canada 60 births (Ontario College of Midwives 2001), before receiving registration.

It is crucial that agreed standards in education are established nationally that are consistent across curriculum and regulation and that provide the baseline for ongoing practice regulation.

### Midwifery practice regulation

Practice standards are another important aspect of regulation and exist alongside the growing emphasis upon quality assurance and evidence based protocols and policy in health care.

In Australia, course accreditation standards, evaluation systems and processes to ensure standards of midwifery and nursing education and practice, vary from state to state. There is not an explicit link, agreed minimum standards or any benchmarking possible between the different Boards, as might be expected through the examination of regulations. This is not 'managed' consistently either, with some Boards or Councils for example, not having an identified professional officer in midwifery or even an equivalent person responsible for midwifery as one of several portfolios. Arguably, Board personnel with a broad generalist role would not be able to keep up to date with relevant issues such as evidence based midwifery practice and policy development.

Two of the key objectives of the Australian Nursing Council are to:

- develop and be guided by a strategic view of statutory nurse regulation in the national and international contexts;
- apply a continuous quality improvement approach to its activities (Australian Nursing Council Inc. 2001).

The actual structure, processes and outcomes related to these objectives with regard to midwifery practice is not evident in the current legislative documents available to the profession and the public. See for example the Annual Report of the Australian Nursing Council Inc. (2000) and the website of the Council (Australian Nursing Council Inc. 2001) in which midwifery is not identified at all.

## Identification and recognition of midwifery

All Nurses Acts in Australia currently see midwifery as a 'branch' or 'specialty' of nursing and therefore refer to midwives as nurses. This has serious implications for the regulation of those midwives who have never been nurses and who would not seek to hold themselves out as nurses. There are anecdotal reports of increasing numbers of 'direct entry' midwives from countries such as England, New Zealand and Canada seeking registration in Australia. In some cases these persons are being 'licensed' to practise both as midwives and as nurses. In one case, a midwife who was refused registration in one state in Australia proceeded to obtain registration in New Zealand without difficulty. Under mutual recognition (Commonwealth of Australia 1992), this midwife could register in her new home state in Australia who had originally refused to register her. (Personal Communication, 2000).

In all but three states, midwives are automatically presumed to be competent as a nurse and practise under a Nurses Code of Ethics. To date, three states (Victoria, Queensland and Tasmania) have also developed their own individual codes of practice for midwives (Nurses Board of Victoria 1999; Nursing Board of Tasmania 2000; Queensland Nursing Council 2000). It is unreasonable, unsafe and probably unlawful to expect people who have never identified as nurses to self regulate as nurses within documentation that, in some parts of Australia, does not explicitly include the nomenclature of midwifery and midwife. It is therefore inappropriate to simply suggest within the statutes that nomenclature for midwife/midwifery may be used interchangeably with nurse/nursing (Nurses Board of South Australia 1999). It is unacceptable, irrelevant and arguably dishonest to ask a midwife at registration, to describe her/his previous experience as a nurse when, she/he has only ever worked as a midwife. Increasingly, this also applies to midwives who no longer work in nursing and identify solely as midwives, and to midwives who have only very occasional access to midwifery practice.

Each of the state and territory Acts provide for the Boards to have specific powers enabling the practice of midwifery to be 'controlled'. These powers appear to be directed at controlling any attempt by non authorised persons from practising midwifery, although midwifery practice itself is not defined. In all states midwifery requires a separate authorisation from the Board, following registration as a nurse. Practising midwifery is illegal unless the person is a medical practitioner, or a student nurse, midwife or doctor 'under supervision'. Where the term 'supervision' is used, it is not always defined. Only the Nursing Acts of Tasmania (1995) and South Australia (1999) attempt to do so by providing an interpretation of the term 'supervision' to include: "oversight, direction, guidance and support" with the South Australian Act (1999) adding to this...."whether given directly

or indirectly". The New South Wales Nurses Act (Nurses Registration Board of NSW 1991) states that a person must not practise midwifery without authorisation unless they are a medical practitioner, a person rendering emergency care or:

> *"any medical or nursing student, or accredited nurse, acting under the supervision of a registered nurse authorised to practise midwifery, or the supervision of a medical practitioner"*
> (NSW Nurses Act 1991 Part 2 Section 7).

The public have no way of determining the efficacy and safety of particular arrangements that may be under the auspices of midwifery 'supervision'. It is important that consumers are able to identify qualified persons and make 'informed choices' around their maternity care options, particularly in NSW where they may be receiving care from 'any' level of nurse or medical student under 'supervision' (NSW Nurses Act 1991 Part 2 Section 7). Protection of title is important in contributing to the public's perception of the distinction between the professions of nursing and midwifery. As stated in the NSW Health Issues Paper (NSW Health Department 1999) specifically prepared to assist in a review of the Nurses Act in that state:

> *"The objective of title restriction is to protect the public by ensuring that consumers are able to identify qualified persons"* (p26).

In addition to protection of the title 'nurse', which is universal in Australia, four states (NSW, ACT, Victoria and SA) restrict the use of the title 'midwife'. Protection of title is of little use if the documentation produced by the Boards, is confused and implies that nurses and midwives are one and the same. For example, whilst not enshrined within law, the Boards of NSW and Tasmania both state that they 'accept' the current definition of a midwife as endorsed by the World Health Organisation' (Nurses Registration Board of NSW 2000; Nursing Board of Tasmania 2000). Significantly, this definition states that "a midwife is a person" and does not in any way state that a midwife must also be nurse (International Confederation of Midwives 1990).

**Table 2: Purpose of the Act and nomenclature used for recognition of nurse, nursing, midwife and midwifery for each for each state and territory**

| Act | Purpose of Act | Interpretations within the documents |
|---|---|---|
| New South Wales 1991 | To regulate the practice of nursing and to repeal the Nurses Registration Act 1953 | RN: person reg. under this Act. Person authorised to practise midwifery must be entitled to be registered nurse |
| Australian Capital Territory 1988 | To provide for the registration & enrolment of nurses, supervision of nursing education and standards, and related purposes | RN: person reg. as general nurse, mental health nurse, or midwife; 'practising' in this Act means practising in any branch of nursing |
| Northern Territory 1984 | To provide for schools of nursing and the registration and enrolment of nurses | Nurse: person reg. or enrolled under the Act. General nurse: person whose name appears on the registry under general category of nursing; Midwifery nurse as above but on category of midwifery. |
| Queensland 1992 | To provide for registration and enrolment; practice of nursing, education of nursing and related purposes<br><br>S 3 Objective : to make provision for ensuring safe and competent nursing practice | Nurse: registered or enrolled nurse. Midwife: person authorised to practise midwifery.Nursing Course: course to educate persons in nursing and midwifery. Nursing Practice: includes midwifery, psychiatric, and any other area of nursing practice. Nursing qualifications: includes midwifery, psychiatric and any other area of nursing. |
| South Australia 1999 | To provide for Registration and enrolment of nurses, regulate nursing for purpose of maintaining high standards of competencies & conduct by nurses, to repeal 1984 Act, other purposes | Nurse: person reg or enrolled under Act Midwife: person authorised under this Act to practise midwifery. Midwifery: care assistance, or support provided to a mother or child in relation to pregnancy or the birth of a child. Special practice areas: midwifery, mental health nursing, any other area of nursing recognised by the Board as being special practice area |
| Victoria 1993 | To protect public by providing registration for nurses & investigation into professional conduct and fitness to practise of RN; to establish Vic Nurses Board; repeal 1958 Act, to provide for other related matters | General nurse / maternal and child health nurse / midwife means person registered under Division 1 of the register; |
| Western Australia 1992 | To provide for regulation of the practice of nursing, registration of persons as nurses, repeal 1968 Act and related purposes | Nurse: a person registered; Speciality means a particular branch of nursing recognised by the Board as requiring particular qualifications approved by the Board |
| Tasmania 1995 | To provide for the registration and enrolment of nurses, the regulation and practice of nursing, the repeal of the Nursing Act 1987 and for related purposes | Nurse: a person registered or enrolled as a nurse; midwife means a registered nurse authorised to practise midwifery; practise means practise nursing; midwifery is a restricted area of nursing practice |

The need for a clear distinction between midwifery and nursing is underpinned by the fact that, following completion of an appropriate educational preparation and registration within the Act, midwives are *practitioners in their own right*. This differs for all other areas defined as specialities in nursing. Within the Acts, midwives are not required to consult with doctors unless there is a medical need. Midwives are qualified to provide primary care across a clearly defined spectrum of time in a woman's life. The period of care is usually the antenatal, intra-natal and postnatal period up to either twenty eight days or six weeks following childbirth. In most developed countries other than Australia, this period of time is explicit within the regulations which make provision for midwives to have legal responsibility for this clear and well defined sphere of practice (UKCC 1998).

The internationally recognised definition of a midwife states that:

*"A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.*

*She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service". (International Confederation of Midwives 1990).*

## Other issues of quality in regulation

Determination of recency of practice is another area of regulation where there is significant inconsistency between the various regulatory systems. In some states registration continues indefinitely, even if a midwife is no longer practising or has not practised for many years (Nurses Registration Board of NSW 1991). 'Practising' is not defined or clearly identified as 'clinical practice' although one authority provides a 'limited' registration to allow for research or teaching only (Nursing Board of Tasmania 1999). Every state except NSW has a '5 year clause' that requires a midwife to complete a re-entry program (often in nursing). Most allow continuation of registration as a midwife even if working exclusively as a nurse with an implied assumption that practising as a nurse also keeps an individual up to date in midwifery. Whilst it may be argued that recency of practice is the responsibility of the individual and or the employing authority, in the current climate of workforce shortages, it is possible that such expectations are not consistently adhered to. Similarly, in such situations of workforce shortages, midwives who have not practised nursing for many years, or even not at all, may be sent to work in nursing areas. Again, protection of the public and adequacy of regulatory standards is questionable and should be a matter for concern.

To date there is not universal agreement regarding nationally competency standards for midwifery practice or education in Australia, and as such continuing professional competence is addressed in a variety of different ways by each of the Boards. In some states (for example SA), midwives are required to declare competence as a nurse using the Board approved competency standards for the registered nurse (Australian Nursing Council Inc. 1998). The principle mandate of the ANCI (of which all state and territory Nurse Boards are stakeholders), is to lead a national approach in developing common standards for statutory nurse regulation. Since inception and to date the ANCI have shown no evidence of endorsing national standards for midwifery practice or education. ANCI continue to utilise nursing standards in their assessment of overseas applicant's suitability for registration and competence to practice midwifery, and in assessment of the midwifery educational programs these applicants have undertaken. This is inconsistent with the contemporary international approach to midwifery regulation

Currently, only one Board requires practising midwives to declare competency on an annual basis using the ACMI Competency Standards for Midwives as the standard (Australian College of Midwives Inc. 1998; Nursing Board of Tasmania 1999). Of concern is one Board (NSW) that does not require nurses or midwives to declare any degree of competence before receiving annual renewal of registration.

Concerns about the regulatory standards of education of new midwives may also be applied to the re-education of midwives returning to the workforce. Currently, in Australia there is no evidence of any requirement for refresher programs to be of a certain standard with regard to content, duration or outcome measures. In 2000 a change in the Tasmanian regulatory framework demonstrated how many midwives do not re register when stringent mechanisms are put in place that require them to declare competence in their field. Section 5.2 in the code of Practice for Midwives in Tasmania states:

*"All midwives are responsible and accountable for their own practice. They must act within the sphere of midwifery practice and are expected to maintain the necessary competence for safe and effective practice. The standard in Tasmania is the ACMI Competency Standards for Midwives". (Nursing Board of Tasmania 2000).*

In one year following the release of the Competence to Practise Policy (Nursing Board of Tasmania 1999) the numbers of practising midwives registered in Tasmania dropped markedly (Street 1998). This is further evidence that loose legislation is not enabling the Boards to meet the objectives of the Act. This action also adds strength to the argument that midwives or nurses will choose not to work in areas where they are not recently familiar or competent, when given the opportunity to declare their self competence and individual scope of practice for safe care. Table 3 describes current regulation standards by State and Territory regarding declaration of competence, existence of a code of practice for midwifery, and recency of practice requirements for midwives in Australia.

**Table 3: Annual declaration of competence requirements, existence of recency of practice clause and code of practice for midwives in Australia, by State and Territory..**

| State/Territory | NSW | NT | ACT | QLD | VIC | SA | WA | TAS |
|---|---|---|---|---|---|---|---|---|
| Annual declaration of competence required - | no | no | no | yes | yes | yes | no | yes |
| Type of competency: Ns = nurse Mid =midwife | - | - | - | Ns | Ns | Mid | - | Mid |
| Recency of practice clause (5 years) | no | yes | yes | yes | yes | yes | yes | yes |
| Code of practice for midwives | no | no | no | yes | yes | no | no | yes |

The issues of recency of practice and continuing competence are both complex and important. In terms of protecting the public this should reflect a national standard to allow for the mutual recognition of accreditation from other states and territories around Australia. It appears essential that Australia moves toward a national system whereby midwives and nurses must declare that they have maintained competence in one or both disciplines and that they have determined for themselves that they are safe to practise. The Acts should ensure that standards are employed rigorously and appropriately in the regulation of both professions in order to protect the public and promote and maintain standards of care. This is an important principle if Boards do not see their role to monitor practice standards in any other way. These issues raise significant questions surrounding refresher and re-entry programs including who provides them, as well as costs, content, standards and audit and quality measures in place.

Employers need to be able to expect that a midwife registered in another state is of a similar standard to that expected in the state in which they seek to practise. This is assumed to be more straightforward since the Mutual Recognition legislation was enacted in 1992 (Commonwealth of Australia 1992). This Act was introduced to address some of the difficulties created by state and territory differences and to facilitate the registration process for health professionals moving across borders. The effect of this legislation was supposedly to provide uniformity and consistency in addressing prerequisites for registration and streamlining the process of registration for practitioners who moved from one state to another. Despite this Act, there remain significant differences in the relevant legislation between the states and territories that is highly problematic. Similar concerns have recently been raised regarding the regulation of nursing in Australia in which the author identifies the need for the development of a national template for the regulation of all health professionals (Bryant 2001).

## Current context

There is recognition by some employers as well as researchers of the need for the standard of midwifery education to be reviewed in light of developments in models of care, as well as concerns about standards of practice and recruitment and retention of midwives (Tracy, Barclay, & Brodie 2000). Under the auspices of the Australian College of Midwives (ACMI) several universities across Australia are developing innovative collaborative approaches to midwifery education that include a set of national standards for the accreditation of three-year Bachelor of Midwifery programs. This form of midwifery education will be developed in Australia over the next few years, with eight Universities reporting that they intend to commence three-year programs in 2002 and 2003 (Australian College of Midwives Inc. 2001; Leap 2001). In March 2001, the Australian College of Midwives (ACMI) Bachelor of Midwifery National Taskforce distributed in draft form, *Standards for the Accreditation of Bachelor of Midwifery Programs* to the eight Nurses Boards. This is part of the ACMI's attempt to develop standards and a national framework to ensure excellence and compatibility in the accreditation of midwifery education programs used across the country. It is hoped that eventually, these standards will be used for approval of all courses and education providers in all institutions offering courses leading to registration as a midwife. At the current time however, as the current Acts are constituted, Nurses Boards are not obligated to adopt these standards. It is proposed that a peer review panel constituted and convened by the ACMI will make recommendations to the registering authorities for course approval (ACMI, Personal communication, 2001). This most significant and formal attempt by the midwifery profession to seek national recognition of midwifery standards and competence will challenge the current regulatory system and further highlight its limited capacity to respond at a national level.

## Conclusion

It is clear from the analysis of the various acts and regulations affecting midwifery in Australia that serious inadequacies exist. The lack of consistency and evidence of discrepancies in the standards of midwifery education and practice regulation nationally, raise concerns about the capacity of the current statutes to protect the public adequately and ensure that minimum professional standards are met.

The development of national standards in midwifery education and a three-year Bachelor of Midwifery intensify the urgent need for regulatory change to bring Australia into line with other Western countries. Appropriate national midwifery competency standards that meet consumer and practitioner expectations and that can be used to guide state and territory regulations, are urgently needed.

Membership of the ANCI and all Boards of the future will need to recognise midwifery as distinct from nursing in order to ensure that 'profession specific' issues are addressed by the relevant group, with involvement of all key stakeholders. Midwifery and consumer representation should be evident on all bodies concerned with midwifery practice and education standards as well as with peer review and complaint mechanisms regarding the professional conduct of midwives. Currently this is neither consistent nor effective nationally. Specific midwifery representation is reflected in various ways, through board membership, the existence or otherwise of practice review committees and ad hoc processes of consultation with the professional midwifery and consumer groups.

The Boards have a role to play in educating the public to understand regulation and to enable discrimination regarding the significance of the title 'midwife' in terms of the role, as well as the different body of knowledge and scope of practice of midwives. The public needs to be aware if they are receiving care from a midwife, a nurse, a doctor or a student of any health profession. Protection of title is of little importance unless the public is educated to understand the significance of the title and how they are protected under the Act. Nomenclature should be addressed so that midwifery practice is clearly identified and to enable the regulation of midwives who are not nurses or who are no longer or have never been competent to practise in both professions. The skills and practices of each profession are distinct and different and the public has a right to this information. Any revision of regulation should ensure that the nomenclature refers to nursing or midwifery distinctively so that the public and empl0yers can be properly informed.

The ANCI have been responsible for a range of initiatives that demonstrate their commitment to and achievements for the profession of nursing. These include the development of a Code of Ethics for Nurses; a Code of Professional Conduct for Nurses and National Nursing Competency Standards for the Registered and Enrolled Nurse. It is essential that these same endeavours occur for the midwifery profession, for both midwives and consumers of maternity care across Australia. Universal adoption of the ACMI Competency Standards for midwives and a national Code of Practice and Code of Ethics for midwives would be an appropriate move forward in addressing some of the inadequacies and discrepancies identified. If self- assessment of competence is to be adopted universally, processes of maintenance and self- declaration must be established and recognised as national minimum standards. It would be desirable for the Boards, in partnership with ACMI, to explore these as well as the international systems and mechanisms for maintenance of midwifery standards to determine what constitutes appropriate professional activity and the best way forward regarding policy on these crucial issues.

## Acknowledgments

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Alana Street, Executive Officer, Australian College of Midwives Inc. provided information regarding ACMI competency standards and codes of practice for midwifery.

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# LETTER TO THE EDITOR

Australian midwifery regulation in the Northern Territory

30 January 2002

Dear Editor

The article on Australian midwifery regulation by Pat Brodie and Lesley Barclay (AHR, vol 24 no 4 2001) was brought to the attention of the Nursing Board of the Northern Territory. Members of the Board were alarmed by a number of factual inaccuracies reported in the article and the fact that this article was able to be accepted for publication with so many inaccuracies.

## Legislation

A new nursing act was enacted in the Northern Territory in October 1999. Surprisingly, the article in the Australian Health Review refers to the old nursing legislation *(Nurses Act 1984)*. This legislation was repealed when the new act was passed.

## Australian College of Midwifery Incorporated (ACMI) competency standards

The Nursing Board of the Northern Territory endorsed and adopted the Australian College of Midwives Competency Standards for Midwives in 1998, making it one of the first nurse regulatory authorities to do so. The article stated that only three nurse regulatory authorities had in fact adopted the competency standards. This is clearly incorrect.

Following the adoption of the competency standards they have been used to form the basis for the development of midwifery programs in the Northern Territory. The competency standards are also used when midwives seek to re-enter the profession after a period of non-registration. The midwife must be assessed as competent against the competency standards prior to the Board issuing a practising certificate.

Also since the introduction of the *Nursing Act 1999*, all midwives in the Northern Territory have been required to complete a self-declaration of their competence to practise midwifery and to declare that they practise in accordance with the ACMI competency standards prior to being issued with a practising certificate. Again the article incorrectly states that a self-declaration of competence is only required in Tasmania and Queensland.

Members of the Board are most concerned that at no time did the authors contact a member of the Board or the Board's professional staff seeking clarification on any matters in relation to the legislation, the competency standards or declarations of competency. A simple phone call would have provided accurate information. The article, as published, presents grossly inaccurate information, refers to non-existent legislation and certainly does not present a true picture of contemporary midwifery regulation in the Northern Territory.

Yours sincerely

Sandra Smiles
Chair, Nursing Board of the Northern Territory

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# Letter to The Editor

Midwifery regulation in the Northern Territory

20 February 2002

We write in response to a letter from the Chair of the Nursing Board of Northern Territory that was published in Issue 25 number 3 of the AHR, in respect to our paper on midwifery regulation that was published in Issue 24 number 4. The Chair of the Nursing Board raised three matters, and we will cover them in turn below.

## Issue 1: our use of out-of-date information

The Northern Territory Nursing Board has a right to be concerned with our citing of out of date legislation if indeed this was the case. We conducted the data collection and analysis during May - June 2000 at which time the primary data source 'Australian Legal Information Database' cited the Nurses Act 1984 as the current legislation for nursing and midwifery in the Northern Territory. We did not check for any updated legislation on this location before submitting the paper for publication, nor was it foreshadowed there. We extend our apologies the Northern Territory Nurses Board for this omission, but the terms within which the research was conducted were clear. Perhaps we could have been specific in the limitations section that any recently updated regulations could not be identified.

Upon discovering the omission we proceeded to review the more recent Northern Territory Nursing Act 1999 and repeat the analysis. In keeping with the original aim of the research, we analysed the new Act and regulations to determine their adequacy in regulating the education and practice of midwifery. We drew upon the legislation that was current on 1 February 2002 in the Australian Legal Information Database – that is, the Northern Territory Nursing Act 1999 and the Nursing Regulations 1989.

It appears that, in spite of new legislation in the Northern Territory, our analysis remains essentially the same. As in most states and territories across Australia, there is confusion about the role of the midwife and a lack of consistency and standards within regulation that places Australian midwifery out of step with most other western countries. Discrepancies in the standards of midwifery education and practice regulation nationally are evident and this limits the capacity of the current Acts to protect the public.

The long title of the Northern Territory Nursing Act 1999 states that it is: *'to provide for the registration and enrolment of nurses and the regulation of the practice of nursing and for related purposes'*. Further, within the new Act midwifery continues to be defined as 'a restricted practice area of nursing'.

Such nomenclature has serious implications for the regulation of midwives who have never been nurses and who would not ever seek to hold themselves out as nurses. Increasing numbers of 'direct entry' midwives are now entering Australia from countries such as England, New Zealand and Canada. In addition, there are several Universities across Australia about to embark on three-year Bachelor of Midwifery degree programs. Under mutual recognition, these midwives should have no barrier to registering in any state in Australia as midwives, not nurses or (as stated in the Northern Territory Nursing Act 1999) 'midwifery nurses'. Under current legislation, the Northern Territory Nursing Board and several others will be challenged to accommodate these graduates. In a climate of severe midwifery workforce shortages our paper was designed to raise concern and debate about these issues. We intended to highlight the need for national consistency in the regulatory framework for midwives that clearly identifies midwifery and enables the necessary health services reform to occur in a manner that both protects the public and enables the appropriate education of the profession.

## Issue 2: competency standards

The letter suggests that our paper is incorrect in its reference to the non-adoption of the Australian College of Midwives Inc. (ACMI) competency standards by the Board in the Northern Territory. We have returned to our original data source (the ACMI National office) to clarify the information that we received in June 2000. Indeed, as you point out, the ACMI Competencies have been endorsed and utilised by the Board since 1998. Confusion had arisen within the ACMI with documentation cited from October 2000 which refers to the Board's decision not to endorse the 'Validation of the Midwifery Competencies Report'. Nomenclature and language is confusing in the communication on this matter by stating that a nurse 'must declare competence to practice in midwifery' and also that he/she must use the 'ACMI beginner competencies'. Neither the researchers nor the ACMI are able to identify any document so titled. Nonetheless the Table 3 on page 113 of the article should be amended to reflect the correct status of the Northern Territory with regard to annual declaration of competency.

## Issue 3: contact with the Nursing Board

The letter reports the Board's concern that at no time did the researchers contact a member of the Board or the Board's professional staff for clarification on any matters relating to the legislation. As we identify in our paper, the design of the study was such that we analysed the documented legislation only, that is, the material available in the public domain. Indeed this was one of our underlying premises for the study. Our method was to conduct a systematic content analysis including a search for the basic attributes and common features found in most forms of professional regulation. Themes, contrasts, gaps and inconsistencies were highlighted and compared across each of the statutes. It was not our intention to interpret how legislation was enacted or what processes the Boards engage in during the course of implementation but rather to analyse the documented Acts and legislation as they are available in the public domain.

We trust that this addresses your concerns and thank you clarifying the information with regard to the Nursing Act 1999 in the Northern Territory.

Yours sincerely,

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# Consumers as arbiters of professional practice? What does this mean for users of maternity services?

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## Abstract

The new managerialism applied to the delivery of health services (and, therefore, maternity services) proposes (among other policies) to empower consumers. The Victorian government has commissioned studies of models of consumer participation to explore which model is most appropriate to redress the recognised asymmetry between users and providers. The Duckett report (Health Services Policy Review 1999) proposes 'consumer empowerment' whereas the Department of Human Services *(Communicating with Consumers Good Practice Guide to Providing Information 2000)* has proposed 'consumer collaboration'. The DHS model uses a productivist model of knowledge. The Duckett model uses an objectivist, or medical/scientific view of knowledge. The DHS model is a genuine partnership model which points to the development of midwifery over obstetric models of maternity care.

Draper (1997) argues that consumer participation is encapsulated in the following way:

> Finding a voice means that you can get your own feeling into your own words and that your words have the feel of you about them

Draper points out that a shift from the term 'patient' to 'consumer' represents a revolution in the way we conceptualize the status of the users of health services. The shift to 'consumer' obviates the idea that people are socialised into definite roles — as in Parsons' concept of the patient role. As Draper argues, the term 'consumer' has some positive connotations: it denotes someone who has a right to receive a service (instead of someone who is grateful to receive a gift) and it denotes a collective right of consumers to have their interests met. As Draper says, consumers want and are entitled to 'information, choice, safety, fair treatment and redress' and these are usually spelt out in a patients' charter. In the ethics literature, the rights approach to the term 'consumer' implies a consequentialist approach — the rightness of a service or its credibility can be judged on the consequences for consumers. In other words, services or treatments should be evidence-based and verified by research that people will be improved by receiving the service.

## From the Welfare State to the Market State: from citizen to consumer

The shift to the term ‘consumer’ from ‘patient’ also highlights the context in which services are delivered (in this case, health services). We have now shifted from the Keynesian welfare state to the market state, which is more like a shift back to classical economy theory. It implies a shift from the ‘citizen’ who has a right to equality in health services to the ‘rational consumer’ who is intrinsically empowered to pursue their own interests (Hancock 1999:48-68; Gardner 1995:211). This has happened mainly because of globalisation; capital has shifted to the global stage and now the sale of information rather than material goods constitutes premium economic activity. It occurs seamlessly and instantaneously among firms via the internet, satellite communications, global telephones, email and faxes. When capital no longer needs to comply with state regulations regarding economic exchanges, the state loses substantial control over capital and over taxation. The ability of the state to redistribute income via the welfare state becomes attenuated and nation-states lose their power base and their centrality in the redistribution of income, services and infrastructure. The state responds by privatising and contracting out services formerly undertaken by public authorities. The system now looks like it did before the post-war welfare state in the sense that the state has opted out of the responsibility for social and infrastructural services. The state has moved from classic liberal conservatism (minimal state intervention with an emphasis on the Invisible Hand) to neo-liberalism in the post-war period and then to a new version of classic liberal conservatism called managerialism. It denotes a minimal role for the state. The state sets policy but contracts out functions and relies on the individual to purchase their own education, health and housing needs according to priorities they set themselves.

Under the new managerialism, public corporations have to act like private corporations in terms of

- Accountability for results (evaluating programs for outputs or efficiencies measured in economic terms);
- Empowering consumers through funding consumers rather than providers (i.e. vouchers for students instead of funding for universities; partial funding of health insurance instead of public funding of hospital services);
- Streamlining bureaucracy by:
    - Governance or ‘steering not rowing’ or withdrawal of state intervention in market decision-making i.e. government only performs core functions like controlling interest rates and legislating for a level playing field while the periphery is left to the market and to individuals;
    - contracting out and privatising services; and
    - new forms of control and accountability referred to as the ‘new managerialism’ with a focus on economic efficiency and flexibility, or the principles of corporate management imported into the public sector

(Hancock 1999:53-5)

Consumerc as arbiters of professional practice?

In this paper, I want to explore the 'empowerment of consumers' under managerialism, or economic rationalism. It needs to be noted that economic rationalism is underpinned by rational choice theory. It assumes that 'humans are motivated in their political and economic behaviour to maximise self-gain ….the individual is deemed as 'unitary, calculating, egoistic, motivated solely by the economic end of accumulating wealth by means of profit maximisation' (Hancock 1999:58). In effect, economic rationalism means that '…power resides in the hands of those who control databases from which rational decisions can be made and by which they can be justified. Comprehensive information gathering is therefore critical to the process'. (Gardner 1997:208). Governments have stepped out of detailed management in favour of metaanalysis; 'the new manageralism' means centralisation of control with decentralisation of responsibility to the private sector, to department heads and to individual consumers.

## Decentralisation of control — Consumers as arbiters of professionals

The curious element in the new managerialism applied to the health sector is that consumers are not entirely relegated, as Duckett argues (in Gardner 1997:202) to a subordinate role under managers who control the databases. Rather, the consumer has made a new appearance as a robust actor in a doctor/patient partnership or, more precisely, as an arbiter of professional performance. At least this is potentially the case although there is a contradiction between the Duckett Report, Health Services Policy Review (1999) and the Department of Human Services (DHS) Communication with Consumers Good Practice Guide to Providing Information (2000) in terms of how to depict consumer control.

The Health Services Policy Review (1999) for example, noted the asymmetrical power of providers over consumers which handicapped consumers in making informed choices about the services available to them in the market. Their solutions included the establishment of a twenty-four hour call centre, advising consumers on access to health problems; self-care; accreditation status of public and private hospitals; public hospital waiting lists; alternative locations for treatments; and the relative performance of public and private hospitals. Performance of all practitioners would be measured against universal risk-adjusted performance indicators.

'Consumer collaboration' (Department of Human Services 2000) and 'consumer empowerment' (Health Services Policy Review 1999:99-127) are terms which convey the imperative that consumers must now be given access to information so that they know why they are being treated, what other treatments might be available, what is the risk of taking any treatment option and what is the risk status of the practitioner according to a set of risk-adjusted performance indicators. Such risk-adjusted clinical performance indicators should be 'comprehensive, consumer focused and current' (HSPR 1999:117). From 1 July 2002 the indicators will be published providing for consumers comparative performance information for public and private hospitals and day procedure centres. Health providers will be legally required to provide such

information to enable the Department of Human Services to measure comparative performance. Consumers will be legally empowered to access their health records. The incoming Bracks Labor Government in Victoria endorsed the Health Services Policy Review recommendations (commissioned under a previous Liberal government), at least as they related to consumer empowerment and the provision of quality care.

## What do these new developments mean for women seeking maternity care?

Before discussing the implications for female users of the health system, it is apposite to point out that state intervention in providing support for consumers still utilises a concept of the consumer that is little changed from classical economic theory. The rationale behind the push to improve '... consumer empowerment is the foundation stone of competition. Transparent competition should lead to quality improvement which, in turn, enhances consumer satisfaction' (Health Services Policy Review Final Report 1999:99). The consumer is still conceptualised as a unitary, stable and rational individual. Further, the recommendations assume that the consumer is generic and, thus, that no differentiation occurs in the interests of consumers. In other words, the Duckett report (Health Services Policy Review) assumes a modernist theory of power and subjectivity. Related to the medical encounter, power is still held by the practitioner who possesses expert knowledge of disease states and illnesses that can be generalised to bodies universally.

The notable difference between the Health Services model and the DI-IS model is that the latter employs a different theory of knowledge from the Duckett report. Under the Duckett (Health Services Policy Review) report, practitioners are required to be accountable for what they do. They are required to act more respectfully towards consumers, especially in terms of giving them information about their disease states, about waiting lists for surgical procedures, about the performance of individual practitioners and hospitals and granting the right of consumers to access their records. But under the Department of Human Services Communicating with Consumers Good Practice Guide to Providing Information, there is due recognition (at least at the top of the range) that consumers should **actively participate in the development of new models**. This is a very different model of consumer participation:

> Consumers are asked to identify the information/education they would like to receive and the appropriate process for receiving it. Consumers and providers work together to develop appropriate information resources and processes. In the process of working together, new knowledge is developed.

Under this premium model (and there are seven models in total ranging from consumer control over information provision to no control over information) consumers are assumed to be experts about their own body (at least in part), their own health needs and certainly the context in which they manage their bodies. The model recognises that consumer information needs to be inserted into the medical encounter so that knowledge can be created through the medical encounter itself. This is a

radical departure from classical economic models because under this model, the consumer is not just informed about knowledge which is already out there. The consumer is a vital cornerstone in creating the knowledge in true partnership with the practitioner who collaborates in investing their own clinical and theoretical knowledge. Both parties have to collaborate to produce the knowledge.

The difference between these two models, 'consumer empowerment' (Duckett's Health Services Policy Review) and 'consumer partnership' (DHS Consumers Good Practice Guide), may be posed in terms of two theories of knowledge and power: the bio-medical view of knowledge, or the objectivist approach, and a productivist or discursive approach. The latter is sometimes referred to as a 'partnership model' (Guilliland and Pairman 1995); a holistic model of care (Davis-Floyd 1992); or a 'public health model of care' (Wagner 1997).

## Models of knowledge

Rothfield (1995: 174-180) differentiates between two models of knowledge and intervention. Medical intervention assumes that knowledge (by the doctor) is separate from the object of the knowledge (the body). Under this model the doctor is the expert with the knowledge of the patient's body, while the patient is ignorant and subject to the expertise of the Other. Further, the hospital and the clinic institutionalise both the doctor's knowing and the patient's ignorance. Rothfield calls this the objectivist approach to intervention because it assumes a '*givenness and independence of reality*'. This model also accords with the 'naturalistic body': an analysis of the body adapted from an eighteenth century pre-social, biological model (Shilling 1993:41). From this perspective, essential differences were derived from physical differences which allowed social and cultural inequalities to be grounded, or 'naturalised' in biological differences (Laqueur 1987:19). Bodily differences were therefore employed to justify what were really social arid culturally constructed inequalities. This 'naturalistic' view of the body also fed into a medical view of the body as essentially pathological. Bodies will inevitably break down and need intervention by expert 'fixers', and women's bodies, in particular, will break down more often because they are not only different from men's but also more fragile. Their physical attributes, therefore, mirror their 'essential' or 'natural' social inadequacies, and vice versa. As Oakley (1990:65) has argued in her review of modem obstetric practices, 'obstetrics treats the body like a complex machine and uses a series of interventionist techniques to repair faults that may develop in the machine'.

A productivist approach assumes that knowledge is discursively produced; that is, that knowledge issues from a specific sociohistorical context, forms of representations, institutions and social practices which position and produce subjects of knowledge. In hospitals, the objectivist model is dominant because, as Foucault (1973) has demonstrated, medical science has been the dominant discourse of social control in Western societies since the Enlightenment. In Australia, Willis (1989) has traced the professionalisation of medicine since the 19th century where all competing knowledges, including midwifery, were subordinated to the scientific paradigm and

institutionalised in law, medical recruitment and clinical practice in hospitals.

It is therefore plausible to understand why woman-centred midwifery remains subordinate to medical knowledge and accounts for a miniscule 4% of accessible models of maternity care (Halliday 1999). This is despite mounting evidence that this model achieves better mortality and morbidity outcomes and where women are more emotionally satisfied with their care and the birth and that better physical and psychosocial health is maintained in the longer term. The models may be contrasted quite simply by saying that the productivist model recognises the importance of the dynamism between the individual and the social context. The objectivist model regards bodily changes as emanating from chemical and muscular impulses. The objectivist model is a scientific paradigm; the productivist model is a social paradigm. These theories of knowledge connote different theories of the subject.

## Post-structuralist theory of power and subjectivity

For Leonard (1997) the concept of the 'subject' has two meanings; the first refers to the humanist subject, and infers that the individual is autonomous, self-directing and able to act within society with a fair degree of choice, or agency. Individuals, within this concept, are rational, autonomous and responsible for their own actions. They occupy the centre stage of history. The social and historical context is of little importance in the construction of individual identity or in directing individual actions, thoughts and intentions. The term is implicit in theories of economics and psychology and implicitly features in the Health Services Policy Review Final Report. The second meaning of 'subject' refers to the idea that the individual is subject to some other authority or direction than an inner-directed self such as the sovereign, or economic and social forces. In this paradigm, the individual has been 'decentred' from a central place in history and attention becomes focussed instead on the social and historical forces which comprise and to varying degrees determine individual identity. The first meaning of 'subject' belongs to humanism; the second meaning to structuralism. The binary division of agency verses structure comes out of these two competing philosophical traditions which sociology has long tried to reconcile.

Drawing on Foucault's notion of the 'microprocesses of power relations', and particularly his proposal that where there is power (or discourses) there is resistance, Leonard (1997:47) argues that the binary division is not useful; that ' . . .power and freedom are not mutually exclusive. We are neither entirely socially constructed nor are we entirely autonomous subjects — [power and freedom] are in continuous interplay'. So, although we generally internalise a particular world view through the influence of dominant discourses, we still retain the ability to resist these dominant discourses. This ability comes from the inconsistencies or contradictions within and between the economy, the state, the family and the forms of mass cultural production. That is, dominant discourses contain contradictions which are felt at the level of everyday life and actual experiences (Leonard 1997:48). It is this gap between the dominant discourses and everyday life which leaves room for resistance, for change, and for a fluid, multiple subjectivity. Leonard urged us to attend to Foucault's notion

of constitutive power — a power that constitutes subjectivities and which operates to control and to enable resistance. A post-structuralist view sees power as both controlling and enabling — both are in constant interplay. It is this theory of the subject that is implicitly being invoked in the Department of Human Services concept of the 'consumer' and 'consumer collaboration'. For the DHS model, the consumer resides in genuine partnership with the practitioner to create the knowledge base.

## Consumers of maternity services

What kind of relationship conventionally exists between the obstetrician and the mother? Does it lend itself to this new idea about consumer participation? Since the obstetrician by virtue of their medical training and medical worldview will most likely work with an objectivist model of knowledge, it is necessary to find other arrangements and models for the delivery of maternity care. A midwifery model is much more hopeful because the midwife's role is actually defined in relationship to the mother and the relationships is defined as a 'partnership'. Not all midwives will embrace the 'partnership' version of the model.

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# Multiple visions or multiple aversions? Consumer representation, consultation and participation in maternity issues

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**Abstract**

*This paper reviews the Commonwealth government's policy of 'purposeful reporting to customers'. I argue that the notion of consumer participation is under-developed. Consumers' needs will not be fully met by confining consumer representation at the administrative level; that is, in assuming that consumer advocates may speak for other consumers of health care services. The partnership objective at the heart of 'purposeful reporting' may be addressed fully only when practitioners and providers recognise the reciprocal expertise of the consumer in defining their own health priorities. This would require a new mobile of knowledge, of ethics and of the clinical encounter. The problem is not one of information deficit but of contrasting views of knowledge.*

**Key words:** *Consumers, participation, reporting, knowledge, managerialism, objectivism, productivism, dialogic relationship*

## Introduction

Economic rationalist policies adopted by both major political parties in Australia in the l990s have pinpointed community involvement as a measurable criterion of academic performance and for funding purposes. Some sociologists have felt committed to community work for its own sake but the process is often fraught with disillusionment even when both sides actively seek to overcome pronounced philosophical and practical differences. This paper is about the benefits and disadvantages of working within the Australian health care industry; in this case, of negotiating with providers in the maternity/ obstetrics arena. The following describes a case study of consumer participation in rewriting the Clinical Report of a large, ter hospital in Australia. The process involved negotiation with health professionals over how to define birth, over which knowledge counted as real' knowledge, and how to measure 'real' knowledge. In this paper, I want to explore the implications of the so-called shift to the 'empowerment of consumers' under 'new managerialism', or economic rationalism. I argue that the notion of consumer participation is under-developed. Inclusion in the formal structures of decision-making, monitoring and review of professional services ('purposeful reporting') is not sufficient. Consumers' needs will he met fully only when medical practitioners are able to acknowledge the equivalent expertise of the consumer in defining their own health priorities. This requires a new model of knowledge. First, we need to ask what it means to he a consumer.

## The rise of the consumer: economic rationalist responses to citizenship

Draper (1997) points out that an increased emphasis on the consumer in health systems in Western democracies represents a major break with traditional views of users of health services. As she argues, the term 'consumer' has positive connotations. It obviates the idea that people are socialised into definite roles — as in Parsons' concept of the patient role — but denotes someone who has a right to receive a service, as opposed to someone who is grateful to receive a gift. Further, it provides an assurance that the person will exercise a collective voice with other consumers to have their interests met within the health service. Draper cites these as 'information, choice, safety, fair treatment and redress'; all of which may form the basis of a patient's charter. From an ethical rights perspective, the term 'consumer' implies a consequentialist approach - the rightness of a service or its credibility can be judged on the consequences for consumers. Services or treatments should be evidence-based to ensure that the consumer's health will be improved by receiving the service in negotiating the content of the Annual Report published by one major metropolitan hospital in Australia, the consequences for consumers of a range of maternity procedures and practices was the central focus of the discussions. But how did the user get from 'patient' to 'consumer'?

## From the welfare state to the market state: from patient to consumer

The shift from patient to consumer occurred with the transition from the Keynesian welfare state[1] to the market state (Hancock 1997: 48-68; Gardner

1995: 211). This is more like a shift back to classical economic theory or a shift from the citizen to the rational consumer. The role of government, or what is now called 'governance', is to perform 'core' functions and to leave the periphery to the market and to individuals. This has happened mainly because of globalisation; the accelerated worldwide intermeshing of economies, ...cross-border traffic and communication. Globalization means global effect and global awareness' (Nederveen Pieterse, 2000). Under globalization, the sale of information rather than material goods comprises premium economic activity. It occurs seamlessly and instantaneously via the internet, satellite communications, global telephones, email and faxes. When capital no longer needs to comply with state regulations regarding economic exchanges, the state loses its control over capital and over taxation. The ability of the state to redistribute income via the welfare state becomes attenuated, nation-states lose their power base and their centrality in the redistribution of income, services and infrastructure. The state responds by privatising and contracting out services formerly undertaken by public authorities. The system now looks as it did before the post-war welfare state in the sense that the state has opted out of the responsibility for social and infrastructural services. The state moved from classical liberal conservatism (minimal state intervention with an emphasis on the Invisible Hand[2]) to neo-liberalism[3] in the post-war period. This is sometimes called the 'borderless world' (Nederveen Pieterse 2000:9). However, from the 1980s and 1990s onwards there has been a shift to a new version of classical liberal conservatism. This new version of classical liberalism is called managerialism. It denotes a minimal role for the state. The state sets policy but contracts out functions and relies on the individual to purchase their own education, health and housing needs according to priorities they set themselves (Hancock 1997).

Under the new managerialism or economic rationalism, public corporations have to act like private corporations in terms of achieving economic efficiencies, empowering consumers rather than providers, taking a peripheral role in market decision-making, and contracting out and privatising services (Hancock 1997:53-5). Economic rationalism is underpinned by rational choice theory which assumes that 'humans are motivated in their political and economic behaviour to maximise self-gain ...the individual is deemed as unitary, calculating, egoistic, motivated solely by the economic end of accumulating wealth by means of profit maximisation' (Hancock 1997:58). Also, as Gardner argues economic rationalism gives power to those specialists who control databasesfrom which rational decisions can be made and by which they can be justified' (Gardner 1995: 208).

#### Decentralisation of control — consumers as arbiters of professional practice

Although the new mandarins of economic rationalism are those who control data-bases, there is a new emphasis on consumer responsiveness. Specifically, in the Final Report of the Health Services Policy Review (HSPR) commissioned by the Victorian Minister of Health (in agreement with the Commonwealth Minister for Health), Duckett and Hunter (1999) argued that the market for health was distorted because of the asymmetry between consumers and providers. 'One of the reasons for government involvement in the health care market was to redress the information and power advantages of the provider over the patient' and later '… consumer empowerment is the foundation stone of competition ... which, in turn, enhances consumer satisfaction' (Duckett and Hunter 1999: 99). Potentially, therefore, the consumer is posited as an arbiter of professional performance. The report suggested manifold strategies to redress doctor/patient information imbalance, including: the establishment of a twenty-four hour call centre advising consumers on access to appropriate care; encouraging self-care; the publication of consumer-relevant information such as the accreditation status of public and private hospitals, the length of public hospital waiting lists, alternative locations for treatments, private health insurers related to hospitals and performance outcomes for public and private hospitals. The publication of performance outcomes means that the performance of all practitioners will be recorded and measured against risk-adjusted performance indicators for perusal by consumers. These will be published from 1 July 2002 for every public and private hospital and day procedure centres so that the state and national Departments of Human

Services may measure comparative performance and provide consumers with adequate information to choose among providers. Consumers will also legally be empowered to access their health records ( and Hunter 1999: 117). These are hefty qualifications imposed upon provider power. They demand more stringent forms of accountability and thus grant to the user a much stronger position than was the case with the 'patient'.

However, and this is the argument in this paper, the invitation to be included in decision-making about health care remains a hollow promise unless the positivist nature of Western medicine is discarded in favour of a theory of knowledge which recognises the equivalent expertise of the consumer. The consumer must be positioned in a dialogic relationship with the practitioner where it is acknowledged that knowledge is created out of the medical encounter. In this dialogue, each party is endowed with expertise and agency 'Purposeful reporting to consumers' is a cogent example of a positive, but inadequate, step towards consumer empowerment because it continues to work within the 'objectivist' model of knowledge (Rothfield 1995, see below) inherent in the medical gaze.

#### 'Purposeful reporting to consumers'

Purposeful reporting emerged from concerns for the iatrogenic causes of illness highlighted in the Australian government funded Quality in Australian Health Care (formerly Australian Hospital Care) Study The study was based on the analysis of over 14,000 admission records from 28 hospitals during 1992. It found that a significant proportion of people [16.6% or 2,351 of 14,210 cases] admitted to Australian hospitals had suffered adverse events - unintended injuries or complications - as a result of their health care' (Australian Health Ministers' Advisory Council [AHMAC] 1996:1). Many were deemed potentially preventable (1996: A9). The most common of the Human Causes were: complication or failure in technical performance (43%); failure to decide or act on available information (20%) and failure to follow-up (15%). The most common System Error Causes were attributed to policies and protocols (38%) and education and training (28%). The clinical situations most commonly associated with adverse events were technical problems (36%); failed care processes (31%); infection 23%; and delay 20%. Frequencies of the medical specialisms associated with adverse events were surgery (21%), orthopaedics (13%), obstetrics and gynaecology (13%) and internal medicine (10%). Adverse events also occurred between specialities, not just within them. Incidents of high potential for harm shared contributing factors: errors in diagnostic judgement; problems in coordination of care (poor communication between professionals); poor communication between patients and health professionals. These formed the basis of prevention strategies found in 'purposeful reporting' (AHMAC 1996, A49-60).

Up until the latter half of the 1990s little information existed about consumer preferences. Consultations by the Consumers Health Forum of Australia revealed that consumers defined quality of hospital care in terms of: accessibility, safety, good communication, economic efficiency and the right to confidentiality, respect, informed consent, clear explanations, improvements in the system and accountability (Consumers Health Forum of Australia 1996). But government initiatives did not emerge until after the publication of the Quality in Australian Health Care Study (Gibberd et al 1996; AMMAC 1996) when governments were prompted to promote consumer participation through a policy of purposeful reporting'.

'Purposeful reporting to consumers' on the quality of health services recognised that:

- *information must be directed towards the consumer;*
- *consumer-defined measures of quality must be included alongside provider-defined measures;*
- *information be available in a consumer-friendly mode; and*
- *consumers must be involved in quality improvement processes*

(Commonwealth Department of Health and Aged Care 2000).

This policy formed the *raison d'être* of the Consumer Focus Collaboration Strategic Plan. The Plan was validated by all Australian health ministers in 1998. It was designed to improve accountability and responsiveness of the Australian health care system to consumers, to facilitate the delivery of health information to

consumers, to galvanise active consumer participation in planning, delivery monitoring and review and to promote education and training to encourage consumer participation (Consumer Focus Collaboration 1998). To expedite the arbiter role of the consumer, the Federal government funded the National Resource Centre for Consumer Participation in Health (of which the Health Issues Centre was the lead agency) whose aims and objectives were to provide advice about consumer feedback and participation in health and to act as a clearing house for information about methods and models of community and consumer feedback. Another strategy was the convening of a National Workshop 'Reporting on the quality of health services to consumers' by the Commonwealth Department of Health and Aged Care comprising providers, consumers and administrators to critique a set of draft principles and guidelines for providers reporting on the quality of health services to consumers (mentioned above). A number of publications created jointly by the Consumers Health Forum and the Health Advisory Committee of the National Health and Medical Research Council were also proposed for distribution to consumer organisations and providers. The titles included 'Improving health services through consumer participation'; 'Guides on Education and Training for consumer participation in health care'; 'Feedback Participation and Cultural Diversity'; and 'Reporting to Consumers on Quality'.

#### Rewriting the hospital's clinical outcome and services report to consumers - the 'Report Card'

The express aim of rewriting the Hospital's Annual Report was to improve the hospital's accountability to consumers; to engage consumers as *equal partners*[4] in decisions about their health care, and to engage consumers in the ongoing cycle of quality improvement of the hospital's services. From the outset it was clear that profound philosophical differences existed at the most fundamental level; notably, how to construct birth. This fundamental schism shaped all preceding discussions about what to include in the Report and fuelled debate about what kind of evidence presented could he regarded as 'factual' and reliable.

#### How to construct the report card: dichotomous views on birth

In terms of how to construct childbirth, providers regard it as a physical and mechanistic event. An obstetrician working within the medical model would want to know whether the head of the baby would fit through the pelvis and whether there have been previous and/or current obstetric or medical masons why the mother's body could not efficiently expel the foetus. This is a separation model of birth (Davis-Floyd 1992). Under this model, the doctor and the baby form the primary relationship because the doctor is the expert and the efficiency of he mother's body is always under question. It is often quoted by obstetricians that one can only judge a birth as safe in retrospect. In other words, birth is a high-risk procedure. Since all births are potentially dangerous and all bodies at risk of malfunction, the doctor must marshal a range of medical, technological and surgical equipment to continuously monitor the progress of the baby throughout pregnancy, particularly during labour, and then get the baby out as quickly as possible. Inevitably, therefore, the mother is relegated to an intervening variable. Her agency must be compromised to allow the obstetrician to manage the birth in the safest way possible for the baby and, of course, the mother. She is relegated to a minor role because medical staff take over decision-making. Success under this model is defined as a live baby and a live mother at the end. That the context is always perceived as one of danger (and heightened fear of potential litigation) (Tito 1996), explains the high rates of intervention in Western hospitals.

#### Dichotomous models of knowledge

Rothfield (1995:174-180) calls this an objectivist model of knowledge because it assumes that knowledge owned by the doctor is separate from the object of the knowledge, the patient's body. The doctor is the expert knower of the patients body, while the patient is ignorant about their own body. Logically, therefore, the patient is subservient to the superior knowledge of the Other. Following Foucault (1973; 1980), Rothfield identifies the hospital and the clinic as central to the institutionalisation of the medical discourse as the dominant paradigm in health care and in individual treatment regimes. It is called an objectivist model because it assumes a 'givenness

and independence of reality. This model is heir to Cartesianism in that the body is an object, like any other. The human body forms a continuum with the animal body but is more complex in physiological organisation. The model refuses to acknowledge the specificity of particular bodies, the role of the social context in the fashioning of bodies and that bodies 'construct and in turn are constructed by an interior, a psychical and a signifying view-point, a consciousness or perspective' (Grosz 1994:8).

For some consumers, the idea that the obstetrician is always and only superior in terms of their knowledge was untenable. A focus group of mothers had been drawn from a population of new mothers who had attended a regularly-held consumers information forum called 'Choices for Childbirth'. It had been convened by a mother with young children who wanted to provide extended information to women in the community about a wider range of choices than would be typically made available through hospital antenatal classes. These women were atypical in that they were tertiary-educated, older and caucasian. However, all were either first or second-time mothers who had given birth recently in major hospitals in the Victorian metropolitan area. Some were midwives. The proceedings were conducted by a professional facilitator skilled in focus group research. The discussion revealed that the women wanted: to be respected by the hospital and the practitioner; to feel confident that their choices would be respected at any time throughout the birth process; to remain in control; to have their expectations and beliefs valued and their experiences recognised and that these admissions would be incorporated into the care within the system. One mother articulated the consumer viewpoint by describing the practitioner in a service role. This denotes an important departure from the 'equal partnership' model of purposeful reporting. For this group of consumers at least women were equal 'knowers' about their bodies and their babies and certainly possessed sovereignty over their own values and priorities. The woman was in charge, not the provider. No provider could hope to guess what their preferences were for the birth, so no decisions about care could be taken unless they dictated them. In short, no amount of 'expert' medical knowledge could prevail over individual choice. For these consumers, birth was not about separation but about putting the mother in the centre of the decision-making process.

Rothfield (1995) termed this approach a productivist model of knowledge because, unlike the objectivist medical model, knowledge is produced as a result of the encounter and is informed by larger social practices, institutionalised knowledges and forms of representation. This model of knowledge supercedes both Cartesian dualism where the body and mind remain separate and Spinoza's monism where body and mind are parallel processes without interaction (Grosz 1994:10-13). For the new mothers in the focus group, there was an intuitive understanding that the body would only perform adequately if they were respected, if their views were honoured and supported and if they remained in control of choices throughout their birth. Although the practitioner was an expert functionary, their knowledge was only useful within the terms of the framework set by the women themselves. Success for this group was measured by the quality of the processes and relationships throughout the maternity career. Of course, they wanted to survive with their babies, but being alive at the end was a minimum condition. The optimal experience was to remain healthy with their personal integrity intact. Although the group represented only one category in a large diversity of consumer sentiment, many studies on consumer satisfaction in maternity services testify to the importance raised by the group regarding maternal control, respect and autonomy (see, for example, Victorian Department of Health 1990; Hodnett 1993; Brown and Lumley 1997; Oakley et al 1990; Oakley et al 1996; McCourt et al 1998). It is precisely the huge diversity within the consumer community which underlines the importance of individuals representing their own needs within the clinical encounter. One's own representation of priorities cannot he left to a delegate at the institutional level, as 'purposeful reporting' assumes.

The consumer model presented by these women posited an interaction between a non-reductionist materiality that was nevertheless open to seepage from cultural influences. Hence, they understood that the way they negotiated the cultural context in terms of their own gender, race, class etc backgrounds would bear a close relation to the

performance of their bodies during childbirth. No one could usurp their position on that. It also meant that decision-making could not be made on the rights approach to ethics, where decisions would be made on the grounds of the consequences of actions, or the outcomes, defined by someone else. That would merely reinforce the liberal individualist notion of 'informed consent'. Decisions should be made incrementally throughout when the necessity arose. For example, it would be the woman's decision whether to birth in hospital, whether to have the labour augmented, whether to have an epidural, whether to have a caesarean section, whether to walk around during labour or whether to give birth on all fours, The decisions would rest on their needs and not on the need of the practitioner, tor example, to remain standing during the birth or to meet another appointment. Nor would the outcome pander to hospital protocol.

#### Constructing the report card

Both providers and consumers agreed that *Safety of Care* took priority on the Report Card. Perinatal Mortality Rates would be included to show how well that hospital compared with overall State data on risk-adjusted indicators (so that contextual factors such as culture, ethnicity, class, gender, age, and geographical location would not distort the measurement of the actual performance of practitioners, individually and collectively). Under the *Appropriateness of Care* heading would be intervention rates such as induction (for other than strictly prescribed reasons laid down by common healthcare standards), forceps and caesarean section. For the consumer advocates, intervention rates would alert potential users to the incidence of the 'cascade of intervention'. For medical staff, the importance of intervention rates would indicate the extent to which the rate of interventions stood outside common healthcare standards.

Other domains of information then followed: *Access* (waiting times) was agreed upon; and *Information* (an initiative to provide patients with their own records) was agreed upon; as was *Monitoring the safety of care* (updating professional credentials and examining complaints via the Adverse Events Review). However, *Continuity of care* and *Satisfaction* domains became points of contention. The hospital defined *Continuity of Care* as the passing on of information about the patient to local GPs taking over the care of the woman and her baby in the postnatal phase. For consumers, however, information under Continuity of Care should alert users to the availability or not of alternative models of care which put the woman at the centre of decision-making, that is, professional midwifery models. Such information would explain whether the hospital promoted team midwifery (a known midwife throughout pregnancy and birth); whether there was a birth centre (and midwifery-only care); whether the hospital employed a community midwife and whether women had a choice of cater and choice of the same cater throughout her maternity career, Conflict over this domain highlighted the essential schism between the medical model and consumer views about how to construct birth.

Likewise, the *Satisfaction* domain raised irreconcilable philosophical differences. For the hospital, the Report Card would report on existing survey results which compared satisfaction ratings on different models of care, notably questions on whether women had an active say in birthing options and their experiences of care. For the consumers, the macro view was useful but inadequate because the crucial question was whether the nature of the relationship between the woman and her cater encouraged the mother to express their wishes and have their desires met in future decisions about care. In other words, measures of satisfaction should convey whether the practitioner encouraged a dialogic relationship characterised by trust, equality and a respect for the expertise of both in line with the productivist model of knowledge (posited above). Two objections were raised against the inclusion of this information. First, additional resources (finance and staff) would need to be dedicated to the collection of such information. Second, the information about relationships would require qualitative methodologies and would not yield reliable, that is scientific, knowledge. In view of providers, qualitative methodologies, like focus groups, fail to maintain the necessary distance between the subject and the object of knowledge. Of course, this was the pivotal point made by Foucault (1980) that there can be no separation of the subject from the object. The subject is unable to stand outside of or remain separate from the

object of knowledge in order to reflect and report upon it. Indeed, the case study supports Foucault's contention that the subject may only work through discourses of power, which produce subjects of knowledge, or the 'truth'. Knowledge is thus only comprised of discourses that have become dominant through their institutionalisation. The whole process of consumer participation in the writing of the report card reflected that paradigm.

### Conclusion

The problems in trying to negotiate a common set of performance indicators and outcomes fundamentally rested on different views of knowledge and power and how these were constructed into definitions of birth. These definitions reflected the nature of the relationship between the practitioner and the woman and in turn affected which procedures would be valorised, what models of care were made available for women (or not) and what was the nature of the relationship between the carer and the practitioner. The experience of working at the interface of industry and academe has been mixed. Foucault is correct that relations of power (dominant and marginal) create subjectivities. In this case study, the subjectivities became more entrenched in their philosophical worldviews. On the consumer side, the experience of working within an institution that authorised the power of the dominant scientific paradigm created an increased determination to articulate an alternative. Foucault's views on agency are not adequate to encompass that outcome, although recent feminist theory has addressed this (see, for example. McNay 2000; Braidotti 1994; Nicolson 1999).

The whole exercise in rewriting the Report Card shows that purposeful reporting' as it currently stands is inadequate to deal with consumer/ provider asymmetry It is not enough to carve up the consumer landscape into sociological categories such as age, class, gender, ethnicity and culture and say that consumers' diverse needs have been accounted for by giving them an interpreter, overnight stays, more information in a variety of formats and representation on formal boards of planning and review. Purposeful reporting' in its current, broadest articulation merely falls into the liberal individualist ethical prescription of informed consent; the consumer is asked to consent to a choice of treatments which are defined by the dominant powerholder. 'Purposeful reporting' is a progressive public policy but remains locked within a positivist model of knowledge. If one accepts that consumers of maternity services have unique identities or 'nomadic subjectivities' as Braidotti (1994) puts it, and that bodies thus perform idiosyncratically, then the premium model is one where the woman and her carer form a dialogic relationship. It is the model which puts the woman at the centre of the decision-making process. Medical models, by nature of their Cartesian and positivist legacies, eschew this possibility.

In maternity services, the logical solution to achieving genuine consumer participation is to replace the medical model with a professional midwifery model of care (as opposed to obstetric nurse models) because this model defines itself in terms of a dialogic relationship between the carer and the woman. Unfortunately the midwifery model accounts for only 4% of all models of care available to pregnant women in Australia. Unless this fundamental requisite is recognised within strategies for consumer participation, no amount of inclusion on formal structures will suffice to alter the patient/practitioner as asymmetry. The problem is not a deficit of information, hut a fundamental dichotomy in philosophical world views. This dilemma is correctly addressed at the administrative level. It also needs to be tackled at the interactional clinical level and this demands attention to expanded models of care which would lead to alternative choices for women in hospitals and to revitalised curricula for all midwifery and medical trainees.

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**Notes**

[1] The Keynesian welfare state refers to post-war social and economic policy which advocated macroeconomic intervention by government in the regulation of labour and capital.

[2] The 'Invisible Hand' refers to a term used by Adam Smith to denote the hidden power of the consumer to determine what producers would produce by virtue of their choice of consumption of products, especially those that were cheapest to buy The term meant that, ultimately, the consumer was sovereign or exercised the final power in the shape and direction of the market.

[3] Neo-liberalism here refers to Keynesian welfare policies in the post-war period. The Liberal Party moved from an insistence on a peripheral role for government to one where government was central in managing macroeconomic goals such as full employment, economic growth and the provision of widespread social welfare.

[4] My emphasis

# THE WAY FORWARD: THE WIN-WIN SOLUTION OR CONSTRUCTING COLLABORATION

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(Preliminary findings – please do not quote)

## Introduction

This paper is a follow-up study of consumer participation policies in Australian providers. A previous study reported that providers in Australia were generally positive about the idea of including consumers in planning, monitoring and reviewing policies and practices at the administrative and ward levels. It was notable also that Unit Managers of maternity units recognised the importance of including consumers at the clinical level. When asked which model they thought was ideal from among three models (Collaborative, Participatory or Consultative) they overwhelmingly chose the Collaborative Model. This option permitted the maximum input from women at every stage of their maternity career. However, I wanted to explore whether the Collaborative Model was instituted in practice. The objective of the study was then to articulate the necessary conditions for Collaborative Models and, secondarily, to explore the specific features of the Participatory and Consultative Models. The study found that collaboration is necessarily premised on four conditions without which co-operation between all participants (medical, midwifery, management and women) cannot he achieved: (1) a policy directive to ensure that a choice of models of care are in place (for women and midwives); (2) antenatal care is conducted by a midwife: (3) trust exists between medical and midwifety staff (4) women exercise agency in decisions about their birth.

## Consumer Participation in Australian Hospitals

A previous paper surveyed providers' views on consumer participation at the Administrative and Ward levels and found a general willingness to embrace the concept. Providers had instituted many avenues of communication and dialogue with consumers to encourage their input into decision-making about facilities and protocols. However, optimal effectiveness demands consumer input at the clinical level. Since consumers' needs are idiosyncratic, it is only a partial solution to include a representative in decision- making at the institutional level. Put more strongly, no representative may advocate for unknown others since even woman will differ in her values and priorities for procedures at the birth. These may not he known by the woman herself until the moment arrives. Since proxy decision-making is not possible, models of care at the clinical level need to have embedded in them the principle of woman-centredness — a principle that prevails throughout the entire pregnancy and birth. Continuity of care and carer models will ensure this. Studies of maternity care indicate that very few women have access to these models (Darcy et al 2000). The study, therefore, aimed to gather information about (a) what models of care were regarded as the ideal model and (b) the willingness of providers to install the Collaborative Model at the clinical level.

## THE CLINICAL RELATIONSHIP

Managers of maternity care units were invited to rate the following three models of care in terms of which model they thought was 'the most effective'. The Collaborative model is the most democratic of the three models. This model conceptualises the clinical encounter as a dialogic relationship between the woman and the carer. This means that birth is seen as woman-focussed; there is constant dialogue and negotiation of procedures and outcomes between the mother and professional carers. The Participatory model offers a partial opportunity for consumers to participate while the Consultative Model is the least tolerant of consumer input. The three models were listed as below:

> **Participatory:** Information gathered from consumers is integrated into choices made available to women.

Five percent of respondents did not answer this question. Of the remaining 61 respondents 5% cited all three models as being ideal; 6% chose the Consultative Model; 18% cited the Participatory Model and 71% responded that the Collaborative Model was the **ideal** model for the clinical relationship. Embracing the Collaborative model as the ideal model is consistent with the generally supportive response to consumer participation from most providers at the Administrative and Unit/Ward levels. However, the picture is much more complex at the level of actual practise. In order to follow up what happened in practise at the clinical level, a qualitative study of twenty providers, or 10% of the original sample, was carried out. Interviews were conducted with Maternity Unit Managers from hospitals chosen from among the range of settings: private, public, large tertiary, small rural or regional providers. The interview lasted for around twenty to thirty minutes. The objective of the study was to elucidate the characteristics of each of the Models and specifically to articulate the necessary conditions to achieve the Collaborative model (a highly woman-centred, democratic model of care) in practice. Responses were categorised into three major categories: Collaborative Model, Participatory Model and Consultative Model.

First, it is necessary to point out that the interviewees were midwives who had been promoted into management positions. It is reasonably predictable, therefore, that their professional training, ethos and subjectivity would steer them towards choosing some kind of inclusive model of care, such as the Collaborative Model as the ideal model. As Degeling (l998) has demonstrated, nurses and midwives are more likely to opt for collaborative models of decision-making and care. In this study, the midwifery managers followed suit, all choosing the Collaborative model. This is an interesting choice demonstrating a clear preference for a woman-centred model of care. For example, they could have chosen the Participatory model as the ideal, which still ensures participation, rather than equality between stakeholders. Notably, none chose the Consultative model which infers no choice for women and a high degree of obstetric dominance.

**THE COLLABORATIVE MODEL** (Five out of twenty providers)

This category comprised only five hospitals; three were public and two were private. The private hospitals were both small suburban units with around twenty maternity beds and around 400 births per year. The three public hospitals were large units with around forty maternity beds and 2,000-2,5000 births per year.

**Coherence between levels of consumer participation:** It is worth noting at the outset that a high commitment to consumer participation at the Administrative and Ward levels did not necessarily concur with a high commitment to consumer participation at the Clinical level. For example, in one small private suburban hospital the level of commitment at the Administrative Level was low while the commitment to woman-centred care at the clinical level was high. At one large public hospital, commitment was Medium at the Administrative level. Low at the Ward level but high at the Clinical level.

**Woman-centred care:** Woman-centred care had to be policy driven. All providers of Collaborative care had instituted clear policy-guidelines to privilege this approach. One small private hospital also provided other models to meet a range of demands by women. Their usual clientele were older mothers; that is over 30 years (4 were over 35 years) who were middle-class, educated and assertive about their needs. Three large public hospitals had instituted continuity of carer models and woman-centred models through team-midwifery. Other models (for example, conventional obstetric/midwifery care) 'were also made available to expand choice for women.

**The proactive consumer:** The managers of these units stressed the importance of the proactive consumer in operationalising woman-centred care. One small private hospital actively encouraged women to express whatever options they desired. One large public hospital relied upon a local women's health liaison group as a policy sounding-board and as a political pressure group to advocate women's needs. Woman-centred care was only partially possible in another large public hospital with a large contingent of indigenous women because it was not always possible to find out what the women wanted. If the support people were older women, they could convey to the midwives what the mother wanted. If the support people were younger, it was impossible to find out exactly what the mother wanted during the birth. The indigenous women in the area came into the hospital to have their babies as quickly as possible and go home. They were not vocal except if they were in pain. The European women who birthed at the hospital, by contrast, were very expressive and confident about their needs and provided staff with a full birthing plan. In this case, the clinical relationship was categorised as Collaborative but only in the case of the assertive Anglo-European women.

**Cooperation between midwives, obstetricians and women:** Trust was a connecting theme in these cases, yet not all obstetricians were positive about collaborative care models. In one public hospital, some doctors were prepared to spend more time with women to explain things and were concerned that women were satisfied with their care and were interested in what women had to say. Others in the same venue were not interested in spending time with women although there were shifts in attitude towards facilitating consumer needs. In one other public hospital, the doctors preferred the collaborative model because the midwives at the hospital also worked in the obstetricians' room. This arrangement had fostered a high degree of trust. Trust was a strong feature of the other large public hospital. This was a geographically isolated unit with a large turnover of single staff (junior midwives, registrars and

RMOs). The obstetric consultants relied on the senior midwifery staff who had worked there for a long time. The obstetricians had come to respect the skills and competence of the senior midwives and this trust had created autonomy for the midwives. As one Unit Manager put it:

> *I wouldn't say that everyone likes each other, but they do respect the knowledge base at those people and they are very happy to work with it. And that's why the doctors and midwives work well together because the senior midwives are very cluey ladies and they [ the obstetricians] are very fortunate to have them because they have that knowledge base.*

In the private sector, one manager reported that 'the obstetricians were very obliging about women's choice'. In the other private hospital, trust between obstetricians and midwives was obviously a pivotal aspect of the collaborative model. Although the obstetricians had found the collaborative model intimidating at first, they had settled into a supportive attitude mainly because communication was good and this had facilitated a high degree of trust. Although antenatal care was provided by obstetricians in their rooms, the maternity unit kept in touch with women from 28 weeks gestation via telephone. This was enough to foster familiarity and trust between the midwife and the woman.

In the ease of another private hospital located in an affluent Sydney suburb, trust was cited as germane to the efficient provision of care.

> *Our obstetricians are very good. Our midwives say this or that and within reason they do it for us and they have always done it for us unlike the doctors in the rest of the hospital. The doctors like to tell the mothers what they are doing all the time. They give the mothers choices as much as possible. If you have a fetal heart of 60 then the doctor's going to say 'Make your choice do you want a live baby or a dead baby'. But apart from that the guys are pretty reasonable; they'll let them do what they want to do.*

**Midwifery satisfaction:** In the public hospitals, there were two or three models in place from which midwives were free to choose. This allowed the more autonomous-oriented midwives to choose a continuity of carer/team midwifery model where they were on call throughout labour for the same women at any one time. Other midwives slotted themselves into conventional models with rosters and regular hours. In all sites, midwives were rotated between antenatal, labour and postnatal shifts to protect their skills base.

**Intervention rates:** Intervention rates remained close to national averages for roster models of care and reduced rates in the case of team midwifery models. In one large public hospital, the midwives worked in a team alongside the doctors specifically to reduce caesarean section rates to 14%. This also occurred in another large public hospital. The rates for conventional models remained at around 19-24%. Most midwifery managers reported that women requested intervention more now than ten years ago. However this was more likely to occur in private hospitals where women received their antenatal care from obstetricians in the community. Managers believed that when women received antenatal care from obstetricians in private practice, the obstetricians 'set them up' to ask for intervention, typically via strategies for pain management.

**THE PARTICIPATORY MODEL** (Seven out of twenty providers)

**Coherence between levels of consumer participation**: Again, there was no coherence between Administrative, Ward and Clinical levels.

**Woman-centred care:** Woman-centred care is analogous to continuity of care/carer models (team midwifery or caseload midwifery) which were noticeably absent in either the public or private hospitals in the Participatory category. One manager said:

> *The participatory model is the most effective, or realistic, for a private hospital because we Don't have a midwifery model… If they come to a private hospital then the midwives don't get a say in what happens after that.*

Another Midwifery Manager of a very small maternity unit said:

> *We have a lot of autonomy in the birthing suite and on the postnatal floor. But obviously it [collaborative care] doesn't happen because antenatally the women are going to the obstetrician in the community.*

Where there are large numbers of part-time staff, team midwifery is more difficult. The Manager or one large public hospital encouraged a team approach but women did not receive the same carer during labour. Even so, this hospital tried hard to encourage women to participate in decision- making.

> *…with our antenatal classes we do try to encourage women to speak out and to be more involved in their pregnancy care and discuss things with the doctor rather than take everything as gospel. We try and encourage them to participate but.. it's really hard. You are going to get a certain number of women who believe the doctor knows everything. We are trying to get people to be more involved in their health care generally, not just maternity.*

**Proactive consumers:** Consumers in the public system did not always want to be involved. In a large regional hospital, consumer representation on special projects had been hard to achieve. The midwives had responded by carrying out surveys to work out what women wanted and to update services to meet the needs. Clearly, woman-centred care also demands proactive women who are prepared to try midwifery clinics.

**Cooperation between obstetricians, midwives and mothers:** A consistent theme was that midwifery management was compromised in private hospitals where women attended the obstetrician for their antenatal care. Women were primed to request epidurals at around 5-6 cms. Obstetricians encouraged the women to expect pain-free management so that they could be assured of a continuing clientele. Midwives were able to exercise some professional judgement during labour and the postnatal period but only within the terms dictated by a dominant medical framework. Nevertheless, trust was a continuing theme in achieving harmonious doctor/midwife relations:

> *They [obstetricians] are usually very trusting about our judgement. They are happy to have us leave things longer. Everyone knows everyone else pretty well so we all have a pretty good working relationship. It is based on trust, big time.*

Another manager of a large regional public hospital reported:

> *We have a very nice group of doctors here. When the woman is in established labour and everything is normal the doctors are quite happy with what we are*

*doing. If something goes wrong, or if he has a tight schedule, then there is interference.*

Not all relations between doctors and midwives were harmonious in the public system. The Manager of another large regional hospital reported:

> *…the obstetricians [GPs]were kicking and fighting and screaming all the way, absolutely. They prefer a consultative model; they don't tend to give the full range. Theirs is a very medicalised and focussed model, very much paternalistic. Doctors say we are poaching their patients because it hurts their pockets.*

The midwives in this hospital had introduced a midwives' clinic to facilitate more choices for women. They achieved this only through the State government's Maternity Enhancement funding scheme. Obviously, this initiative had irritated the local GPs.

**Midwifery satisfaction:** As expected, midwives felt content when they could work within the model of their choice — autonomous, caseload or team midwifery models or a conventional roster system of care, Managers reported a high rate of satisfaction among midwives when obstetric staff respected their skills and judgement and left a deal of decision-making in their hands.

In one large regional public hospital where the local GPs resented midwifery initiatives to introduce a midwifery clinic and domicilary care system, the midwives experienced a deal of frustration. this was related to an aging medical staff and rigid culture. Around 10-15% of midwives left the hospital to work in other models of care.

> *The doctors really are struggling to accept it [the midwives clinic and early discharge/domicilary care system]. They are a lot of wind but not a lot of action. They Don't trust the midwives a lot except those who agree with them.*

A Midwifery Manager in another large regional hospital explained that doctors rejected midwifery autonomy:

> *Doctors don't like the collaborative model. Doctors prefer the consultative model. If women claim what they want the doctors would offer a medical line. Most doctors have a graph in their head with time limits for all stages. It's not the way nature works at all; it's a medical plan whereas midwives will tend to work more in with how the woman is behaving and how the midwife feels about the progress and she is with the woman the whole time and she can see how things are going whereas the doctor is in and out and doesn't have a clue really.*

A Midwifery Manager of a smaller suburban private hospital also reiterated the antipathy from doctors towards collaboration between doctors, midwives and women:

> *Doctors prefer the consultative model. They are businessmen; they would like to have them [the women] all for themselves and make all the decisions for them.*

**Intervention rates:** A common theme emerged. When women received antenatal care from GPs or obstetricians in the community, a trend towards women requesting or expecting intervention emerged.

> They establish a relationship with the doctors in antenatal care and we lose out because we don't have access during that time so they don't get the same

support and encouragement from us that it is OK to go over time. When they come we've lost that advantage because they expect for that [induction] to happen

**TIHE CONSULTATIVE MODEL** (gout of 20 providers)

**Woman-centred care:** Consultative Care equals strict medical dominance. One manager of a private hospital said of the midwives' ability to operate relatively independently of obstetric supervision:

> *…That's what we certainly try [to work autonomously] but because it's a private hospital and ultimately it's the obstetricians care then I guess it is the medical model. We certainly encourage the women to think about what's happening and to make decisions for themselves and to speak up for themselves. But in the end it's what the doctor says which stays in their mind. They think 'I have to listen to what he's telling me'.*

Another manager of a regional private hospital said:

> *[The clinical relationship] is probably more consultative where options are given to women Doctors tend to tell women what they think is best them rather than asking the what they want.*

Another manager whose hospital had been taken over by a private health corporation said that they had a Collaborative model in situ which had been fully embraced by consumers. However the corporate takeover had reduced all innovations to financial strictures:

> *The private sector is constrained by what obstetricians want and at the a administration level. A handful of obstetricians would have worked differently if they knew the midwives, but not now. We live in such a litigious community they are much happier to have control.*

**Proactive consumers:** A manager of a large public regional provider explained that providing antenatal care automatically privileged the medical (consultative) model. Although doctors possessed a 'great commitment to their clients,' they were 'at the mercy of their own education system and their own prejudices'. The younger obstetricians were happier with a consultative model because medical training had encouraged that approach. He believed that health professionals had relied on their knowledge as a power base to discipline women and ensure compliance. In his view, providers should install a range of options to cater to all needs. However, this was difficult in the country because doctors assumed women would not question their advice and:

> *…in a public hospital in a rural setting women come in and they have accepted a medical model because that's been the shape of their antenatal care and philosophy. When they come in there's not going to he much movement away from that model.*

Another manager from a large regional private provider said:

> *I wonder if women are asking for intervention because the doctor suggests it's a good idea. More people are coming into hospital and requesting elective*

*epidurals ... and there has been a swing away from natural childbirth a few years ago. [Women] think it is really great to have an epidural because you don't get any pain.*

**Cooperation between Obstetricians, Midwives and Mangers:** Some midwives did not like working within the medical model, according to these managers. One manager explained that consumers should have more rights so they were trying to change the care to a midwifery (Collaborative) model. Another manager of a large public hospital said that midwives would prefer to take over as much care as possible and call obstetricians only when something goes wrong. Only then would they need their expertise. In her large maternity unit, (5,500 births/year) they had instituted both the medical model and the midwifery model. Low risk women were free to choose the midwives clinic, the birth centre or shared care (with their GP) whereas high-risk women had no choice. For the manager of another large private maternity unit, the consultative model worked well for midwives and doctors because the women were aged between 35-40 years and wanted a lot of intervention. There was also an IVF clinic in the maternity unit which usually meant a high intervention culture.

Age was a consideration in what model of care was in place. One manager of a small public, suburban hospital said that if obstetricians were over 50 they were unlikely to change:

*When they are over 60 you can't go changing them just like that. You don't want to cause friction in front of patients.*

Another manager said of midwives working within the Consultative model in a large regional public hospital:

*A lot of the older midwives aren't interested because they were trained in a different system and are happy, but the younger midwives coming from the tertiary base are interested in expanding models of care. The hospital based midwives like me were happy with the status quo.*

In term of changing towards a Collaborative model one manager said:

*Down the track but it will be very slow. It will only happen by new obstetricians starting here and by new graduates coming in from bigger hospitals with collaborative models.*

The gradual pace of change was supported by another manager who said:

*That [getting caseload or team midwifery] must happen over a number of years. At the moment they don't have the necessary skill and that's the existing education system… A big incentive for midwives in rural areas is the number of medical practices that are reducing their obstetric load so there is a void there and an opportunity for midwives to get into the market…*

Trust was an important ingredient in harmonious relations but in these eases the obstetricians trusted the midwives not to stray outside of the medical framework:

*It's not worth doing things they would disagree with and if you go about it the right way we don't have any problems with them.*

In other eases, trust was an outcome of the length of service, age of the obstetricians and expertise of the midwives. One manager said that the midwives who had been in

the unit for a long time had taught the residents, registrars and students how to do things and particularly how to look after women in normal labour. Trust developed when people worked together over a period of time.

**Midwifery satisfaction:** About 15-20% of midwives in this category found the lack of autonomy frustrating. A manager of a regional private hospital said:

> *Midwives get very unhappy with the way things happen but they can't change it. In a private situation it's very difficult. We have had midwives change to other hospitals because they can't practice midwifery as they like.*

However, midwives in country and regional areas were often unable to leave because their options for alternative employment were limited. Other midwives experienced frustration but did not leave because they could exercise some autonomy in the delivery suite, especially in public hospitals. Midwives also stay in employment even if they don't like the medical model because they enjoy working at that particular hospital.

**Intervention rates:** Rates were generally high in this category. Rates for Caesarean Section, for example, ranged between 20-35% (national a 21%). One manager of a private hospital said:

> *Standard rates would come down with a collaborative model – if midwives did the births.*

Other managers cited consumer-driven intervention to avoid pain and this was generally attributed to obstetric priming in the antenatal period. Ethnic women were thought to prefer medical interventions and private hospitals were regarded as having higher rates of intervention than public hospitals. There was no mention of women objecting to high rates of intervention or to obstetric dominance.

## Conclusion

Reviews of literature dealing with the effects of consumer participation on professional performance show remarkable resilience to the status quo. Consumers are apparently little affected by performance information in terms of choice of hospital to attend or in terms of demanding more accountability from providers and practitioners. Most professional associations and providers have perceived public arbitration as a threat to professional autonomy. The publication of professional performance indicators have had the most effect on the top and bottom performers. Top performers use the data to market their services and the bottom performers use the data to compete with peers (Robertson 2000). This study adds further fuel to the argument that consumer participation is only partially successful in changing professional performance to more accountable and democratic practices. The study found that most providers welcomed consumer participation at the administrative and ward levels. Managers of maternity units also cited the Collaborative Model as the ideal model to achieve consumer input at the clinical level. However, only a minority of providers have achieved that in practice.

The study revealed that four conditions are necessary to ensure that collaboration occurs among consumers, midwives, obstetricians and management: (1) a policy directive to ensure that a choice of models of care are in place (for women and midwives); (2) antenatal care is conducted by a midwife: (3) trust exists between medical and midwifery staff (4) women exercise agency in decisions about their birth.

The way forward is thus a difficult one because all four conditions require considerable shifts in cultural values from all four stakeholders women, midwives, obstetricians and managers. However, unless these changes are accomplished, the negative features of the current system will prevail - continuing workforce crises, resentment and frustration by midwives and the high social and financial costs of intervention.

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## SENATE INQUIRY INTO CHILDBIRTH PROCEDURES[1]

The following paper is based on the AMAP Submission to the Senate Community Affairs References Committee INQUIRY INTO CHILDBIRTH PROCEDURES August 1999[2].

Terms of Reference

Childbirth procedures, with particular reference to:

(a) the range and provision of antenatal care services to ascertain whether interventions can be minimised through the development of best practice in antenatal screening standards;
(b) the variation in childbirth practices between different hospitals and different states particularly with respect to the level of interventions such as caesarean birth, episiotomy and epidural anaesthetics;
(c) the variation in such procedures between public and private patients;
(d) any variations in clinical outcomes associated with the variation in intervention rates, including peri-natal and maternal mortality and morbidity indicators;
(e) the best practices for safe and effective births being demonstrated in particular locations and models of care and the desirability of more general application;
(f) early discharge programs, to ensure their appropriateness;
(g) the adequacy of access, choice, models of care and clinical outcomes for rural and remote Australians, for Aboriginal and Torres Strait Islander women and for women of non-English speaking backgrounds;
(h) whether best practice guidelines are desirable, and, if so, how they should be developed and implemented;
(i) the adequacy of information provided to expectant mothers and their families in relation to the choices for safe practice available to them; and
(j) the impact of the new Medicare rebate provided for complex births, including the use of the term 'qualified and unqualified neonates' for funding purposes, and the impact that this has had on improved patient care and reduction of average gap payments.

INTRODUCTION

We applaud the *Inquiry into Childbirth Procedures* and believe it to be long overdue. Australia is not alone in needing to rethink maternity services and reorganise the way they are rovided. A similar exercise has occurred in the United Kingdom and some provinces in Canada, and in New Zealand in recent times. Any 'rethink' of systems of maternity care delivery needs to:

- address clinical priorities for care and safety;
- be mindful of the benefit of appropriate primary care services;
- be guided by evidence;
- meet the needs of consumers;
- demonstrate cost benefit and effectiveness;
- be aware of the need to prepare a skilled health workforce, especially in rural areas.

Implementation of 'Best Practice' in maternity care, which is a service provided in the main part for healthy women, requires service providers to actively incorporate consumer's needs rather than work from a basis of professional or provider's preference. Whilst it is recognised that this is not necessarily easy, given the history of shifting maternity care from the GP run 'cottage hospital' and midwife services that predominated up until World War II, to acute tertiary level services of today; it is important to 'recapture' the community orientation and focus on health in maternity care. This is not only to ensure women's needs are met. Australia, and other Western countries must minimise costly interventions that have escalated beyond control or apparent thought of consequence in the last decades, despite evidence that these do not result in safer or more satisfying care for women.

### *(a) the range and provision of antenatal care services to ascertain whether interventions can be minimised through the development of best practice in antenatal screening standards;*

[1] The final report can be found at Commonwealth of Australia (1999) Senate Community Affairs References Committee. ROCKING THE CRADLE: A REPORT INTO CHILDBIRTH PROCEDURES - 8 December 1999 http://www.aph.gov.au/senate/committee/history/index.htm#Community

[2] This submission represented the views of the following members of the research team and presented only the views of these researchers from the Centre of Family Health and Midwifery, UTS, Sydney. Professor Lesley Barclay, Sally Tracy, Pat Brodie

The largest cost factor in the maternity services budget in Australia is the budget for antenatal screening. It is estimated that the cost of obstetric ultrasound for 1997/98 was $39 million , in comparison to $54 million for all other obstetric care that year (Beech 1998). Routine ultrasound in early pregnancy appears to enable better gestational age assessment, earlier detection of multiple pregnancies and earlier detection of clinically unsuspected fetal malformation at a time when termination of pregnancy is possible. However the benefits for other substantive outcomes are less clear ( Neilson 1999). Given that ultrasound has never been proven either safe or effective in reducing infant mortality or morbidity (Pearson 1994), this is a questionable health cost to the nation (Beech 1998). Whilst routine antenatal tests are highly valued by women (Searle 1996, Steer 1993), there is the danger that they may raise the potential for women to consider their pregnancy to be abnormal and develop a reliance on technology and expertise to ensure a safe pregnancy. This heightened perception of risk as a dominant feature of the pregnancy may well be a determinant for the use of other perinatal interventions ( Searle 1996 ). Lupton argues that risk is ' ….not a pregiven objective reality which exists 'out there' waiting to be measured' (Lupton 1995). Similarly the WHO describes risk in childbirth as a dynamic concept needing to be constantly re-assessed (WHO 1996).

In the 1980's Marion Hall questioned 'which causes of death are likely to be preventable by antenatal care? (Hall 1981). The question echoed a decade later by Steer "why has such a pattern of largely ineffective ritual persisted in antenatal care ? (Steer 1993), is as relevant today as it was then. This is not the domain of obstetrics alone. Midwives also question routine antenatal practices and education classes "teaching approaches often promote dependency amongst clients rather than nurturing the decision making skills required by a consumer driven maternity service" (Nolan 1997) and 'classes under institutional control mean that women learn what the institution wants them to know' (Gilkinson 1991). "Current moves to demedicalise and decentralise childbirth potentially providing more continuity of care, are necessitating radical changes in the organisation of maternity care. They should be seen as an opportunity to discard outdated rituals rather than simply to transfer them from doctors to midwives (Steer 1993). Midwives also question the number and frequency of antenatal visits necessary for low risk healthy women and these concerns have been supported and reinforced by recent evidence emerging from several large studies relating to the long term effects of reducing antenatal visits (Clement et al 1999). The midwifery model of care which has as its focus the care of a woman through her entire pregnancy, birth and postpartum episode achieves a sort of relationship where both the woman and the midwife are able to address specific needs and interventions which may strongly benefit the mother and her baby.For example, the midwife may be able to direct more of her energies into a smoking cessation program for a young pregnant woman, or a breastfeeding awareness program. These interventions are too often underfunded and overshadowed by highly expensive antenatal screening procedures carried out in tertiary centres. The AMA in March 1999 identified issues that it felt the government should urgently address such as the duplication of primary healthcare services and an objective assessment of non- medical providers (Thursby 1999).

We recommend that the government should look very closely at the level of public spending in antenatal screening and assess the evidence for its effectiveness.

**(b)** ***The variation in childbirth practices between different hospitals (and different states) particularly with respect to the level of interventions such as caesarean birth, episiotomy and epidural anaesthetic.***

***(c) The variation in such procedures between public and private patients***

***(d) Any variations in clinical outcomes associated with the variation intervention rates , including perinatal and maternal mortality and morbidity indicators.***

In the area of obstetric interventions and decision-making in childbirth practices there are factors which are non-uniform and provider related (Haynes de Regt 1986, King 1993, Lumley 1989). These factors have an important impact on the clinical outcome for women during childbirth. The effect of private and public hospital status on the variations of in obstetric

outcome has been shown for all interventions including caesarean birth, episiotomy and epidural anaesthetic.

**Effect of health insurance status on childbirth outcomes**

**NSW**

Using published data from the Midwives Data Collection NSW 1997 (NSW, DOH 1998), it was possible to compare the most recent data on all private hospital patients with public hospital patients for all the interventions listed. The New South Wales Mothers and Babies 1997 Health Bulletin Supplement was reviewed. See Table 1. (NB raw data only: ie no other analysis has been performed on this data). A conservative estimate shows women who received private obstetric care in private hospitals in NSW were possibly twice as likely to have obstetric intervention as women who were cared for in public hospitals. Note this data does not tell us what happened to women who were privately insured but gave birth in a public hospital.

**Table 1. The risk of obstetric intervention by private and public hospital status for NSW 1997**

| **Obstetric Interventions** | Private n = 14070 | Public n = 72690 | Relative Risk | 95% Confidence Interval |
|---|---|---|---|---|
| **Elective CS** | 1994 14% | 6622 9.1% | 1.5 | 1.48 to 1.63 |
| **Episiotomy** | 3184 22% | 10591 17% | 1.5 | 1.48 to 1.59 |
| **Epidural Anaesthetic** | 5511 39.1% | 15515 21% | 1.8 | 1.79 to 1.88 |

*Source: Unpublished draft, Sally Tracy 1999, raw data from New South Wales Mothers and Babies, 1997 New South Wales Health Department 1998*

**Difference in episiotomy rates for private v public patients** (Shorten & Shorten 1999). A recent Australian study, also using NSW population figures, concluded that private insurance may be a risk factor for obstetric intervention. This study identified that New South Wales private hospital patients experienced twice the rate of instrumental delivery (forceps or vacuum) compared to NSW public hospital patients; and even after controlling for the relationship between rates of instrumental delivery and rates of episiotomy, there remained a 6% to 8% difference in episiotomy rates for private hospital patients compared to public hospital patients (Shorten & Shorten 1999).

**Victoria**

The 1990 Ministerial review on Birthing services in Victoria made reference to the fact that "all forms of assisted delivery were commoner in the private than in the public patients so that while one in five public patients had some form of assisted delivery more than one in three private patients did so" (DOH, Victoria 1990) See Table 2.

**Table 2. Assisted Delivery in Public and Private patients Victorian data 1989**

| | FORCEPS % | **Vacuum Extraction** % | **Elective caesarean** % | **Emergency caesarean** % | **total** % |
|---|---|---|---|---|---|
| **Public** | **11.7** | **4.4** | **6.5** | **5.6** | **25.4** |
| **Private** | **12.4** | **2.5** | **13.6** | **7.1** | **35.6** |

*Source: Consumer Survey, 1989 in "Having a Baby in Victoria" Health Department Victoria 1990.*

**Australian National Figures**

Table 3 shows the variation among the States and Territories in the rates and types of obstetric intervention in Australia 1995. The latest AIHW report of Australia's Mothers and Babies claims that for singleton births of 2500gm and over, mothers who had private health insurance had a caesarean section rate of 23.6%, 54% higher than the rate of 15.3% for those who were not insured (AIHW 1998).

**Table 3. Type of delivery, showing the variation in the rates of operative intervention among the States and Territories, 1995**

| | NSW | Vic | Qld | WA | SA | Tas | ACT | NT |
|---|---|---|---|---|---|---|---|---|
| total births (number) | 86,263 | 62,732 | 47,864 | 25,090 | 19,310 | 6,682 | 4,830 | 3,607 |
| (per cent) | | | | | | | | |
| spontaneous vertex | 71.0 | 67.5 | 68.8 | 64.6 | 63.5 | 70.0 | 63.5 | 72.3 |
| **forceps** | **7.1** | **10.9** | **5.7** | **5.5** | **9.2** | **8.8** | **9.0** | **7.8** |
| **vacuum extraction** | **3.4** | **1.5** | **3.8** | **9.2** | **3.4** | **1.0** | **6.4** | **1.2** |
| vaginal breech | 1.1 | 1.0 | 0.8 | 0.6 | 0.7 | 0.9 | 0.7 | 0.7 |
| **caesarean section** | **17.5** | **19.1** | **20.8** | **20.2** | **23.2** | **18.8** | **20.3** | **19.3** |

*Source: AIHW National Perinatal Statistics Unit 1997, in Australia's Health 1998*

Elsewhere in Australia there have been several reports observing a possible association between obstetric intervention and the economic imperative (King 1993, Cary 1990).

**Cost of operative intervention**

As the pressure on health care funding continues to rise, there will be increasing interest in understanding the costs associated with specific episodes of treatment and in trying to evaluate the overall cost-effectiveness of health policies and programs (AIHW 1998). The male female difference in per person cost is greatest in the peak reproductive years where average annual costs for women aged 25-34 years were $1,716, almost double the average cost of $888 for men of the same age (AIHW 1998). Given that the cost of elective caesarean delivery increases this spending by an estimated $2,500 (Shorten et al 1998) per person cost, there is a real need to ascertain and then address the question of intervention rates for women in childbirth on a national level.

**Other reasons for high operative intervention rates**

For at least a decade it has been accepted that the rates of caesarean section are rising and show very few signs of abating (Read 1990, Hillan 1992, Savage 1993, Brown 1998). The rising caesarean section rate continues to generate much debate (Wilkinson et al 1998) with a recent editorial in *Birth* claiming there was no agreement about safety, evidence or an appropriate caesarean delivery rate. “The experts disagree on all these issues. Although they claim that the safety of mother and baby is their primary concern, in fact, they often have different agendas depending on whether they represent the medical establishment managed care, medical-legal concerns, cost containment turf protection or something else” (Young 1999 p68).

Fear of litigation is widely held to have played a key part in the increase in caesarean section rates in the USA and the UK (Young 1999), but in countries like Canada and Australia where litigation is not nearly so widespread as in the USA, the rate is nearly as high and well over the that for most European countries. (MacFarlane & Chamberlain 1993). We would argue that the risk of fetal or maternal death occurring as a result of anaesthetic misadventure for a non-essential caesarean may increase, and will also begin to be a source of litigation (Personal correspondence.)

Fear of perineal damage from vaginal delivery, and of subsequent stress incontinence and anal sphincter damage (Al Mufti et al 1996) is one reason given for elective caesarean section (Steer 1998). The intent to avoid perineal damage does not explain the often corresponding rise in caesarean section and instrumental delivery rates in the previous studies.In a new twist to the debate Professor Philip Steer asserts that in the competition for survival between fetus and mother, women will seek caesarean section because they fear damage to their vagina and to their fetus without there being any medical indication.

The balance between benefit and harm is pivotal in the debate about obstetric intervention at birth. Although epidural analgesia is associated with more effective pain relief than non-epidural methods it is also associated with adverse effects, including longer first and second stages of labour, increased oxytocin use, malrotation, instrumental deliveries and caesarean section particularly for dystocia (Howell 1999). Issues of long term morbidity such as high levels of urinary incontinence and back ache in the year after birth remain to be excluded as potentially related to increasing use of epidural. Given the potential lifelong complications due to perineal trauma and the shortage of evidence concerning the long term physical and psychological sequelae for women having either elective caesarean births, and epidural anaesthetic, there is a need to determine all likely risk factors predisposing women to operative or instrumental intervention during childbirth. Recent work from Creedy (1999)

suggests the psychological harm experienced by women has been underestimated in number and severity to this point.

Episiotomy overused

In 1989, researchers in Sweden reported that episiotomy had a negative effect on the women's wellbeing was overused and needed to be reconsidered (Rockner et al 1991).In a recent study published in 1999, the same researchers found although there was a reduction in the incidence of episiotomy from 33.7% to 24.5% there was wide variation between hospitals (4% - 50%); and that episiotomy was more common with vacuum extraction and epidural anaesthesia (Rockner et al 1999). Similar studies have not yet been undertaken in Australia.

Midwifery Care is associated with lower operative delivery rates in Childbirth.

Whilst we acknowledge the advantages of specialist care by obstetricians and neonatologists for a certain small group of women in our population who experience problems in childbirth, our approach is to present the evidence for midwifery care for low risk, uncompromised women.

Midwifery models of care were supported by recent reviews of birthing services in New South Wales, Victoria, and Western Australia. In these models, the midwife is the primary care provider for women with uncomplicated pregnancy and childbirth, in collaboration with the medical team and with ready access to consultation and transfer if complications arise. These models of care are also supported in the reports on services provided by midwives (NH&MRC 1996, 1998)

Midwifery care is associated with lower operative delivery rates. Several recent studies have shown that obstetric intervention is linked to the type of care given during childbirth. The effect of the caregiver can not be overlooked in the debate around operative delivery. The questioning by midwives as to the scientific basis for routine episiotomy and lithotomy position at birth has had a positive effect on the reduction of episiotomies (Rockner et al 1999, Sleep et al 1984, Sleep et al 1987). Similarly, women cared for by midwives have lower rates of epidural anaesthetic and caesarean section( MacFarlane et al 1993, Hofmeyer 1999 Leitch et al 1994, Turnbull 1996)

Midwifery care in childbirth has been shown to differ in management in effecting lower episiotomy and caesarean section rates with comparable outcomes to obstetric tertiary level care (Flint 19989, Rowley 1995, Turnbull 1996,Harvey 1996, McCourt et al 1996, Waldenstrom 1998, Hueston et al 1993, Kenny et al 1994, Guilliland et 1998) See Table 4. Continuity of midwifery care is associated with lower intervention rates, with no statistically significant differences observed in maternal and fetal outcomes ( Waldenstrom and Turnbull 1998).

**Table 4. Intervention rates in Childbirth: Outcomes affecting the Mother in Studies of Midwifery Care Compared to Routine Obstetric care: classified as significantly (s) lower, higher or the same[3].**

| OUTCOME | FLINT | ROWLEY | TURNBULL | HARVEY | McCOURT | KENNY |
|---|---|---|---|---|---|---|
| Antenatal admission | lower | lower | | | | |
| induction | lower | lower | (s) lower | lower | (s) lower | lower |
| ARM | lower | | | (s) lower | lower | lower |
| augmentation | (s) lower | higher | higher | lower | lower | higher |
| 1st Stage >6 hrs | higher | the same | the same | | lower | the same |
| epidural | (s) lower | the same | lower | lower | (s) lower | lower |
| analgesia | (s) lower | (s) lower | lower | (s) lower | (s) lower | higher |
| operative vaginal delivery | lower | lower | lower | lower | (s) lower | (s) lower |
| caesarean | higher | lower | higher | (s) lower | lower | (s) higher |
| episiotomy | (s) lower | lower | lower | (s) lower | (s) lower | the same |
| vaginal tears | (s) higher | higher | lower | | higher | |
| intact perineum | the same | | higher | | (s) higher | |
| antenatal ultrasound | | | | (s) lower | | |
| continuous FHR | | | (s) lower | | (s) lower | |
| intermittent FHR | | | (s) higher | | (s) higher | |

*Source: Unpublished MA Thesis Sally K Tracy 1996, Updated 1999*

These tables were compiled so that the results of six intervention studies could be easily compared. The summary is a visual representation of the results of obtained form experimental groups. The clinical outcome rates are represented as **(s) significantly: lower, higher or the same.**

No summary statistical results were calculated or applied.

[3] Note: this is not a meta analysis rather a comparison of findings from published research

Maternal Morbidity

It could be argued that maternal mortality in healthy women in Australia is so low irrespective of method of delivery that attention should be focussed on morbidity. Caesarean section is a major operative procedure and consequently many complications are encountered that are never seen in vaginal deliveries. Most authors ( see for example early work such as that by Farrell et al 1980, Nielsen & Hokegard 1983) agree that women who undergo an elective Caesarean section, as opposed to an emergency operation, have a reduced risk of developing infectious complications in the postoperative period, and the variation in rates may differ by as much as a factor of five (Nielsen & Hokegard 1983). Elective caesarean section, however, does carry a significant maternal morbidity (See Table 4.). In a study by Hillan et al (1995), specific variables used to assess the postoperative morbidity associated with caesarean section were : febrile morbidity; postnatal blood transfusion; antibiotic therapy; urinary catheterisation; wound infection; urinary tract infection; intrauterine infection; and chest infection. Only 9.5% of the women in the study had no recorded postnatal complications during this time, with 302 (49%) of women sustaining three or more problems.

**Table 5. Elective versus emergency Caesarean section: postnatal maternal morbidity**

| complication | elective Caesarean s. n = 220 ( % ) | emergency caesareans n = 399 (%) | |
|---|---|---|---|
| **pyrexia** | 106 (**48.2**) | 251 (**62.9**) | p< 0.001 |
| **blood transfusion** | 3 ( **1.4**) | 18 ( **4.5**) | p< 0.05 |
| **antibiotic therapy** | 35 (**15.9**) | 130 (**32.6**) | p< 0.001 |

*Source: Hillan et al 1995 Postoperative morbidity following caesarean delivery. Glasgow*

In an Australian study looking at maternal morbidity post childbirth, Brown and Lumley (1998) found that compared with spontaneous vaginal births, women having forceps or ventouse extraction had increased odds for perineal pain, sexual problems, and urinary incontinence. These differences remained significant after adjusting for infant birth weight, length of labour and degree of perineal trauma.

A recent meta-analysis by Olsen (1997) showed that the total number of complications, the frequency of fetal distress, the frequency of neonatal respiratory problems and the frequency of birth trauma were significantly and consistently lower in births attended by midwives. Parity and maternal morbidity before the pregnancy was controlled for in all the comparisons. The following potential confounders were controlled in one or more studies: maternal age, maternal height, marriage, length of education, socio-economic conditions, smoking, number of prenatal visits, previous stillbirths, previous infant death and maternal morbidity occurring during pregnancy. Findings regarding lower intervention rates than standard maternity care morbidity are supported by randomised clinical trials of midwifery care for women in childbirth (Flint et al 1989, Rowley et al 1995, Harvey et al 1996). One study concluded that midwife-managed care for healthy women, integrated within existing services, is clinically effective and enhances women's satisfaction with maternity care. (Turnbull et al 1996).

The largest study undertaken in the USA., including all singleton, vaginal births at 35-43 weeks gestation delivered either by physicians or certified nurse midwives in the United States in 1991, found that after controlling for social and medical risk factors, the risk of experiencing an infant death was 19% lower for certified nurse midwife attended than for physician attended births, the risk of neonatal mortality was 33% lower, and the risk of delivering a low birth weight infant 31% lower. Mean birth weight was 37 grams heavier for the certified nurse midwife attended than for physician attended births. The findings discussed in light of differences between certified nurse midwives and physicians in prenatal care and labour and delivery care practices found that midwives provide a safe and viable alternative to maternity care in the United States, particularly for low to moderate risk women (MacDorman MF & Singh GK. 1998)

Neonatal Morbidity

The potential harm to a mother and baby from operative delivery may not always be justified especially when fetal distress may be misdiagnosed. Even with a correct diagnosis it is not clear whether an operative or conservative approach is better. There have been no contemporary trials of operative versus conservative management of suspected fetal distress. In settings without modern obstetric facilities, a policy of operative delivery in the event of meconium-stained liquor or fetal heart rate changes has not been shown to reduce perinatal mortality (Hofmeyr et al 1999). Studies have been undertaken to observe the morbidity of

neonates where deliveries directed by the obstetricians showed higher complication and intervention rates with no differences in neonatal neurological outcome between groups attended by midwives, general practitioners or obstetricians (Berghs et al 1995).

***(e) The best practices for safe and effective births being demonstrated in particular locations and models of care and the desirability of more general application;***
As summarised in Table 4, there is now overwhelming evidence, to add to that provided by NHMRC (1996 & 1998) and WHO (1996), that medically dominated models of maternity care for low risk women are not financially and socially sustainable. They do not represent 'Best Practice' and they do not necessarily produce better health outcomes, when compared to less costly and more woman centred, primary health care models of service.

Recommendations from a number of different reports produced by organisations of standing such as the World Health Organisation (1996), UK Department of Health (1993) and National Health & Medical Research Council (1996), are leading to some change and restructuring of maternity services in Australia. These are designed to increase continuity of midwifery care and improve outcomes, however this change is relatively isolated and is often occurring **despite** structures that work against improvements such as cost shifting between state and commonwealth and territorial disputes from professionals.

MIDWIFE LED MODELS OF CARE AS 'BEST PRACTICE'
Several Australian government reports have recommended changes and reorientation of maternity services to ensure increased continuity of care, greater utilisation of midwifery skills and redirection of maternity services towards the community (Department of Health NSW, 1989; Health Department of Victoria, 1990). Since these reports were released the work of two NH&MRC committees have confirmed the safety and benefits of midwife led care for healthy women (NHMRC 1996; 1998).

These recommendations are consistent with moves internationally where increased costs, women's' declining satisfaction with maternity services and considerably increased morbidity attached to intervention rates, are forcing a 'rethink' of medically dominated systems of birthing. Based on evidence provided by the *Cochrane Collaboration Database of Systematic Reviews* (Hodnett, 1996) and the World Health Organisation (WHO, 1996), it is becoming increasingly recognised that health services need to develop midwifery continuity of care models for low risk women to run alongside and collaborate with obstetric and neonatal services for women and their infants 'at risk'. This evidence highlights:

- women's greater satisfaction with continuity of midwifery care
- equivalent or improved clinical outcomes including reduced morbidity
- potential to reorganise and improve the efficiency of maternity services and reduce indirect costs attached to excessive intervention rates.

**Home Birth**
A meta-analysis of the safety of home birth (Olsen 1997) showed that fewer medical interventions occurred in the home birth group: induction of labour, augmentation, episiotomy, operative vaginal birth and Caesarean section. Furthermore there was a lower frequency of low Apgar scores and severe lacerations in the home birth group (Olsen 1997). New Zealand and the United Kingdom see home birth as a viable, safe and publicly funded option for over stretched and under resourced hospitals that do not compromise safety in screened women and meet many women's needs.

**Midwifery models of continuity of care: Australian evidence**
At the ***John Hunter Hospital*** **in Newcastle**, NSW, continuity of care provided by midwives was demonstrated through a randomised, controlled study with 814 women to be as safe as routine care. It also reduced the need for medical interventions including induction of labour, analgesia use and need for neonatal resuscitation. Women receiving team care were significantly more satisfied with their experience and there was a significant reduction in cost (Rowley et al, 1995).

At ***Westmead Hospital*** **in Sydney**, a randomised controlled trial with 446 women demonstrated improved outcomes for the study group including: reduced incidence of manipulative delivery (6% compared to 14%) and episiotomy (10% compared to 26%);

significantly higher levels of satisfaction with care through all stages of pregnancy; reduced length of hospital stay and a reduction in the overall costs of care (Kenny et al, 1994).

At ***St George Hospital*, in Sydney**, the Outreach Maternity Program (STOMP), being studied and evaluated under an NH&MRC grant, involves six midwives who provide continuity of midwifery care for a total of 300 women per year. In the STOMP model, women are offered the choice of continuity of care by midwives in one of either two community based clinics. An obstetrician attends these clinics and sees women on an 'as needed' basis, according to the midwives assessment. During labour, women are cared for by one of the six midwives in the team, give birth in the hospital and then choose early discharge or short hospital stay. The midwife provides postnatal care either in the ward or at home for a period of 5 – 7 days. Preliminary unpublished data from this large randomised controlled trial, suggests improved clinical outcomes and equivalent maternal and neonatal morbidity rates associated with the STOMP model (Personal communication, Caroline Homer). There appear to be significant cost savings even on very preliminary data from interim analyses). This model of care has been progressively integrated into the mainstream services and there are plans to extend the model further.[45]

In ***Canberra*** in 1995, the Commonwealth Government's Phase Two Alternative Birthing Services Program (ABSP) funded the Community Midwives Pilot Project. This enabled the pilot of an innovative midwife led, community based 'caseload model' of care for 'low risk' women. This small pilot study involving 73 women and their families, determined that, the project provided 'quality maternity care outcomes and good value for money', and predicted "greater economies of scale as the volume of women seeking this type of care increased" (Hambly, 1997, p27). Such an increase has occurred and currently the revised model consisting of 12 midwives is providing total midwifery care to 540 'low to moderate risk' women per year (Personal communication, 1999).

In ***Fremantle*, WA**, the Community Based Midwifery Program (also ABSP funded) was introduced as a pilot project offering low risk women continuity of care from a primary midwife and choice of either home or hospital birth. Ten self-employed, fully accredited midwives are contracted to the project and are paid $1800 per client. The evaluation, involving 120 women reported that community based midwifery-led care is safe, satisfying and provides a viable model of maternity care, whether the birth is at home or in hospital and was associated with low rates of obstetric intervention and high levels of maternal satisfaction. This project cost on average *$1,605* per case in contrast to the average cost of an uncomplicated delivery of $1,905 as reported by Commonwealth Department of Human Services and Health in 1995 (Thiele & Thorogood, 1997). In 1999, the service had their ABSP funding extended to 2001 and the Health Department of WA has recently provided additional funding to secure the program for a further two years enabling it to double it's intake of clients to 150 women per year (Personal communication1999).[6]

The measurable outcomes for these projects are shown in Table 6.

[4] Published results of this RCT can be found in: Homer CSE, ,Davis GK, Brodie P, Sheehan A, Barclay LM, Wills J, Chapman G. (2000) Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard hospital care *Br J Obstet Gynaecol*;108:16-22

[5] A cost analysis of this study can be found in:Homer, C.. Matha, D., Jordan, L., Wills, J., Davis, G. .2001 Community-based continuity of midwifery care versus standard hospital care: a cost analysis. *Australian Health Review*. 24 (1): 85-93.

[6] See also http://communitymidwifery.iinet.net.au

**Table 6. Continuity of midwifery care models ♣ – a comparison of formally evaluated Australian initiatives**

| Location & type | *Description of model of care* | *Births / year* <br> *Staffing FTE* | Features Referral patterns ♦ | Formal evaluation and current status |
|---|---|---|---|---|
| ***John Hunter*** <br> *Team Midwifery* | Tertiary centre; Mainstream / birth centre birth; continuity of midwife care through antenatal, labour & birth | 300 <br> 5.6 (incl.A/L) | All risk | Rowley et al (1995) RCT with 814 women; Reduced interventions, increased satisfaction, reduced costs * See table 4 . |
| ***Westmead*** <br> *Team Midwifery* | Tertiary centre; Mainstream care; continuity antenatal, labour & birth and post natal | 240 <br> 2 X 3.4 (incl.A/L) | Low - mod risk. | Kenny et al (1994) RCT with 446 women; Reduced interventions, reduced length of stay, increased satisfaction, reduced costs * See table 4 |
| ***Canberra*** *Caseload / Team Midwifery* | Tertiary centre; Community based ante & post natal care, birth in hospital / birth centre; continuity of midwife care antenatal, labour, birth and post natal | 540 <br> 2 X 6 (incl.A/L) | Low – mod risk | Hambly (1997) small descriptive study; ABS funded initially. Recently expanded to two teams and fully integrated option. |
| ***St George*** *Team Midwifery* - outreach | Teaching hospital; Community based ante & post natal care with hospital birth; continuity of midwifery care antenatal, labour & birth and post natal | 600 <br> 2 X 7(incl.A/L) | All risk | RCT with 1081 women. Early unpublished data suggests reduction in LSCS. Report due Oct 1999. Two teams fully integrated |
| ***Fremantle*** *Community Midwifery* | Community based independent midwifery model, birth at home or in hospital | 150 <br> 10 self-employed | Low risk | Theile et al (1997) small descriptive study showed cost effective, safe, satisfying. ABS funded. Now expanding with additional state funding |
| ***USA*** *Freestanding Birth Centres* | Community based independent units; some with medical care as an adjunct to primary midwifery care | | Low – mod risk | Rooks et al (1989) Nationwide prospective descriptive study of 11, 814 women in 84 centres. Reduced caesarean section and all other interventions, lower perinatal mortality |
| **ENGLAND** <br> *One to One Midwifery* | Community based continuity of care through all stages with named midwife; lead professional based on risk factors; home or hospital birth (2 hospitals) | 800 <br> 20 (incl. A/L) arranged in group practices | All risk | (McCourt & Page, 1996) Prospective descriptive study with 1400 women, reduced interventions, greater satisfaction, equivocal costs. Integrated, seen as 'Best Practice'. * See table 4. |

*Source: Pat Brodie 1999*

♣ There is considerable diversity between models. It is important to consider the full range of variables that impact on the functional capacity and type of service each model can provide. These variables include: geographical location, casemix of clients, skill mix, flexible work patterns of staff, integrated support services etc.

♦ Referral and consultation patterns vary greatly and are determined locally, either by consensus or policy eg some models provide care for low risk women only; some require between 1 and 4 consultations with doctor whilst others do so based on midwife referral, some include shared antenatal care with GP. Some have immediate access to staff obstetrician / registrar on site.

***( F) early discharge programs, to ensure their appropriateness*;**

Practices surrounding early discharge in maternity have evolved in an ad hoc and unsubstantiated fashion across Australia. This has occurred due mainly to pressure for beds in already crowded postnatal wards and every increasing effort to reduce hospital length of stay. The NSW Obstetric Services Taskforce (Department of Health NSW, 1989) made recommendations that postnatal care for all women should be available up until Day 7. This is still well short of care provided in other Westernised countries such as New Zealand and England where care is provided in the woman's home up until day 10 or 14 and access to a midwife is available up until day 28. This recommendation was later supported by NHMRC (1996) which also highlighted women's preference for an average length of stay following uncomplicated childbirth to be of about five days duration.

Importantly, resource savings associated with reduced length of stay have not been transferred to community based postnatal care. In a recent survey conducted by NSW Health, as part of a strategic planning exercise, it was found that, of the 101 public facilities providing maternity care, only 72 reported availability of early discharge / community midwifery programs (NSW Health Department, 1999). Furthermore, criteria for client selection for these programs is not consistent and appears to be based on availability of resources rather than on women's needs for home based midwifery care. There have been concerns raised re the quality of postnatal care and the effect that different forms of care, including early discharge may have on health outcomes (Cooke & Barclay 1999; NSW Health Department, 1999).

In 1991, 20.2% of women were discharged less than four days following childbirth. By 1996, this had risen to 40.3% (Day, et al 1999). There is an absence of comprehensive evaluation on the effect of reduced length of stay on the health outcomes of women, babies and families particularly longer term outcomes such as adjustment to parenthood, breastfeeding and postnatal depression. Early discharge with midwifery care provided in the home has been associated with more positive feelings compared with those who were discharged early without access to such a service (Brown & Lumley, 1997). In contrast, unsupported early discharge, namely that which occurs without any follow up care in the home has been associated with postnatal depression (Hickey & Boyce1998 ). More research needs to be conducted into postnatal care and the effect that different models of care have on longer term outcomes.

***(G) the adequacy of access, choice, models of care and clinical outcomes for rural and remote Australians, for Aboriginal and Torres Strait Islander women and for women of non-english speaking backgrounds;***

In 1997 Aboriginal perinatal mortality in NSW was 20 per 1,000 live births compared with 9.6 in the non-Aboriginal population (NSW Health Department 1998a). In 1997 the rate of low birth weight in Aboriginal babies was 12%. This is almost double the rate for NSW overall which was 6.1% (NSW Health Department 1998a). Almost 38% of Aboriginal women present after 20 weeks gestation for their first antenatal visit, compared with 15% in NSW overall (NSW Health Department 1998a). This can be associated with many service providers' lack of understanding regarding the special needs of Aboriginal women and mainstream maternal health services being often inappropriate, inadequate and inaccessible for many Aboriginal women (National Aboriginal Health Strategy 1989, Najman et al. 1994, NSW Health Department 1994, de Costa and Child 1996, O'Connor and Bush 1996, Plunkett et al. 1996). As a result many Aboriginal women receive inadequate care during pregnancy, have decreased access to appropriate models of care and suffer poorer outcomes.

The reproductive health status of many Aboriginal women is poor. This is associated with poor nutrition, infectious diseases, high blood pressure, genitourinary disorders and gestational diabetes as well as the behavioural risk factors of smoking, alcohol intake and substance abuse. When examining the disparity between Aboriginal and non-Aboriginal perinatal mortality rates these social, economic and cultural determinants of health must be considered. Between 1988-90 Aboriginal mothers accounted for only 3% of confinements in Australia but almost 30% of maternal deaths (National Health and Medical Research Council 1996).

The following two Aboriginal maternal health programs have demonstrated improved outcomes and are worthy of more general application and expansion to other areas:

***Strong Women, Strong Babies, Strong Culture program Model***: This program has a nutritional and educational focus and is based in nine Top End communities of the Northern Territory. The program was developed by, and for Aboriginal women, and uses the skills of respected Aboriginal women. Strong women workers educate women about pregnancy and women's health and form the link between the antenatal clinics and the Aboriginal community.
*Outcomes:* Women participated in antenatal care earlier; low birth weight dropped from 20% to 11% over 5 years; preterm birth rate dropped from 16% to 14% and there was a decline in rates of sexually transmitted diseases. Concurrent decreases in prematurity and low birth weight in all Top End communities made it difficult to determine the true measurable effect of these decreases, however it is likely that the program had an effect. The program's success is attributed to the 'right Aboriginal people' selected to work on the program, Aboriginal control and empowerment and the program addressing an area of concern for many Aboriginal people (University of Queensland 1998).

***Daruk Aboriginal Medical Service Antenatal Program Model****:* Daruk Aboriginal Medical Service (AMS) is situated in Mt Druitt, Sydney. A full-time midwife and Aboriginal health worker provide shared care with an AMS GP and the Nepean Hospital obstetric team. The program provides antenatal care, birth support, transport, home visits, education and women's health screening and has a particular focus on providing social and family support. It is well known and cited as an example of 'Best Practice' in maternity care for Aboriginal And Torres Strait Islander Women in an urban area.
*Outcomes:* The program evaluation compared outcomes for Aboriginal women who accessed the Daruk service with those of Aboriginal women who accessed mainstream antenatal care at Nepean and Blacktown Hospitals. Thirty six percent (36%) of Daruk women had their first antenatal visit in the first trimester of pregnancy compared with 21% at Nepean and 25% at Blacktown. Despite Daruk women having a higher burden of antenatal risk factors than Aboriginal women at Blacktown and Nepean Hospitals, there was no concurrent increase in perinatal morbidity or mortality.

The program was evaluated within a hierarchy of outcomes which showed that it had been most effective at the levels of creating a culture of antenatal care, developing an effective partnership with a mainstream service and managing pregnancy complications. (Daruk AMS 1998).

***(l) the adequacy of information provided to expectant mothers and their families in relation to the choices for safe practice available to them***
Information provided to women about intervention rates at different hospitals and from different care providers as well as information about the range of choices for care is not readily available to Australian women. Until this occurs women's capacity to make informed choices about many aspects of theirs and their baby's care will be severely and unnecessarily restricted.
Turnbull et al, in South Australia recently reported that over one third of women felt they had not been involved in the decision to have a caesarean section. Many of the women involved in the study expressed a degree of dissatisfaction with their decision or that they may not have been given sufficient information on which to base a decision (Turnbull 1998).
In an as yet, unpublished recently completed doctoral thesis from Griffith University, Brisbane there is compelling evidence to link the level of obstetric intervention experienced by women and the perception of inadequate care during childbirth, with higher levels of 'post traumatic stress disorder' (Creedy, 1999). These findings in association with the large volume of evidence now available re unacceptable high rates of intervention during childbirth should prompt a serious investigation into the adequacy of information provided to expectant women in relation to the choices for safe practices and the consequences of any obstetric intervention.

CONCLUSION
This submission is based on our experiences as midwives and clinical researchers with knowledge of contemporary maternity care and the evidence on models and types of services that are research based and also meet women's needs. While public sector Australian

maternity care continues to reflect the vested interests of the dominant professional groups and the marketers of technology, and reflect the philosophies of acute care in hospitals it will be unable meet the needs of the community or be provided in a manner that is cost effective and safe. The acute hospital model of care for pregnancy and birth increases the rates of avoidable interventions and leads to higher levels of morbidity. We recommend that a greater emphasis and awareness be given to the cost effectiveness and efficacy of primary care offered by midwives.

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## SENATE INQUIRY INTO PUBLIC HOSPITAL FUNDING[1]

The following paper is based on the AMAP Submission to the Senate Community Affairs References Committee INQUIRY INTO PUBLIC HOSPITAL FUNDING, October 1999[2].

Terms of Reference

How, within the legislated principles of Medicare, hospital services may be improved, with particular reference to:

(a) the adequacy of current funding levels to meet future demand for public hospital services in both metropolitan and rural Australia;

(b) current practices in cost shifting between levels of government for medical services, including the MBS, pharmaceutical costs, outpatient clinics, aged and community care, therapeutic goods and the use of hospital emergency services for primary care;

(c) the impact on consumers of cost shifting practices, including charges, timeliness and quality of services;

(d) options for re-organising State and Commonwealth funding and service delivery responsibilities to remove duplication and the incentives for cost shifting to promote greater efficiency and better health care;

(e) how to better coordinate funding and services provided by different levels of government to ensure the appropriate care is provided through the whole episode of care, both in hospitals and the community;

(f) the impact of the private health insurance rebate on demand for public hospital services;

(g) the interface between public and private hospitals, including the impact of privatisation of public hospitals and the scope for private hospitals to provide services for public patients;

(h) the adequacy of current procedures for the collection and analysis of data relating to public hospital services, including allied health services, standards of care, waiting times for elective surgery, quality of care and health outcomes; and

(i) the effectiveness of quality improvement programs to reduce the frequency of adverse events.

### INTRODUCTION

The terms of reference for the Senate Inquiry into hospital funding specifically seek responses as to " how, within the legislated principles of Medicare, hospital services may be improved?". Medicare is the universal taxpayer funded health insurance system that offers subsidised private medical services and free public hospital care for all Australians. Its guiding principles are equal access to equal care for equal need.

This submission from the Australian Midwifery Action Project (AMAP) addresses the terms of reference of the Senate Inquiry with particular reference to the *funding of maternity services in Australia.*

The submission draws together evidence that:

- demonstrates the need to recognise the contribution of midwifery care to the wellbeing of Australian mothers and babies;
- provides an overview of the cost of various models of maternity care currently offered to women who are perceived to be 'low risk';
- demonstrates the detrimental effect of funding a 'fee for service' rather than an 'output based' maternity service in creating overspending and inappropriate care;
- proposes a 'prospective' payment method for funding maternity care based on principles of equal access and health promotion. This funding model alters the emphasis of services from an overuse of diagnostic services and surgical procedures, and is tied to healthy outcomes for mothers and babies;
- suggests ways to increase the access of disadvantaged women to equitable maternity care.

### BACKGROUND

[1] The final report can be found at Commonwealth of Australia 2000. Senate Community Affairs References Committee. FIRST REPORT - PUBLIC HOSPITAL FUNDING AND OPTIONS FOR REFORM. http://www.aph.gov.au/senate/committee/history/index.htm#Community

[2] This submission represented the views of the following members of the research team and presented only the views of these researchers from the Centre of Family Health and Midwifery, UTS, Sydney. Professor Lesley Barclay, Sally Tracy, Pat Brodie

Having a baby in Australia is by any standards a safe event. Consequently the measure of a safe and effective outcome for childbirth in Australia (as in other affluent industrialised countries) has shifted its focus from a measure of maternal mortality that is largely now stable and small, towards measures of maternal morbidity. Notwithstanding, there are some women, indigenous Australian women, those of culturally and linguistically diverse backgrounds and those living in remote and rural areas who are more likely to experience poorer outcomes in terms of perinatal mortality than the community generally (AIHW 1998).
There is an emerging body of research to show that morbidity associated with childbirth is related to the high rates of intervention and operative delivery that are incurred at birth (Fisher 1995, Fisher 1998, Creedy 1999). Morbidity is costly in monetary, social and emotional health terms both for families and funders of health care.

The latest AIHW report of Australia's Mothers and Babies claims that for singleton births of 2500gm and over, mothers who had private health insurance had a caesarean section rate of 23.6%, 54% higher than the rate of 15.3% for those who were not insured (AIHW 1998). Research into the scientific basis for routine episiotomy and lithotomy position at birth has had a positive effect on the reduction of episiotomies (Rockner et al 1999, Sleep et al 1987). Similarly, women cared for by midwives have lower rates of epidural anaesthetic and caesarean section ( MacFarlane et al 1993, Turnbull 1996,Hofmeyer 1999) with comparable outcomes to obstetric tertiary level care (Flint 1989, Tew 1991, Hueston et al 1993, Kenny et al 1994, Rowley et al 1995, Turnbull et al 1996, Harvey et al 1996, McCourt et al 1996, Tracy 1997, Waldenstrom 1998, Guilliland 1998,); and no statistically significant differences observed in maternal and fetal outcomes ( Waldenstrom and Turnbull 1998).

Midwifery care is an important resource within maternity care that is supported by reviews of birthing services in New South Wales, Victoria, and Western Australia. In models recommended by these reviews, the midwife is the primary care provider for women with uncomplicated pregnancy and childbirth, in collaboration with the medical team and with ready access to consultation and transfer if complications arise. These models of care are also supported in the reports on the safety of services provided by midwives and general practitioners in Effective Care in Childbirth (NH&MRC 1996), and Review of Services Offered by Midwives ( NH&MRC, 1998).

***(a) The adequacy of current funding levels to meet future demand for public hospital services in both metropolitan and rural Australia;***
In September this year the Hunter Valley Team Midwifery Project was closed due to inadequate funding levels. This was a public hospital funded team midwifery service that had been operating successfully for ten years and had been found to be safe and accessible to women. At the John Hunter Hospital in Newcastle, NSW, continuity of care provided by midwives was evaluated by Professor Maralyn Rowley through a randomised, controlled study with 814 women and found to be as safe as routine care. It also reduced the need for medical interventions including induction of labour, analgesia use and need for neonatal resuscitation. Women receiving team care were significantly more satisfied with their experience and there was a significant reduction in cost (Rowley et al, 1995).

Other midwifery models of care are similarly facing a bleak future as targeted funds run out and they remain, in general, 'on the edge' rather than integrated into routine services. For example the Alternative Birthing Service funded models of care in Western Australia face an uncertain future. The project evaluation unanimously supported midwifery models of care for all the women who took part (Reibel 1999). Similarly in Victoria the six alternative birthing services funded by the Commonwealth and found to offer all women from a range of socio-economic groups benefit from continuity of care and carer are not to be continued and will not replace the current fragmented arrangements that exploit rather than protect women's vulnerability during childbirth (Lane 1999). These services despite proven safety, high levels of satisfaction and reduced costs have remained marginal to mainstream services offered within most institutions and separate from their funding base. An important exception is the St George Hospital Sydney where a community midwifery team service has developed out of regular funding and become a normal part of options available for women (Barclay).

A recent research report from the Centre for the Study of Mothers' and Children's Health in Victoria found that the constraints in budget expenditure in public hospitals in Victoria had a

very real impact on the quality of care for women during labour and birth. The research also found that recommendations from previous research in 1993 calling for the introduction of team midwifery care and multidisciplinary team care for women 'at risk' had not been implemented and in fact had been reduced in some instances (Brown and Lumley 1998).

Preliminary evaluation from the team midwifery project at the Midwifery Practice and Research Centre at St George in Sydney shows similar beneficial results for women. The St George Outreach Maternity Project, a large randomised control trial, compared the safety, acceptability, cost effectiveness and client satisfaction of an innovative model of continuity of care with the standard model of care. The trial recruited 1100 women over a two-year period. Final data analysis is in progress (Homer 1999)[3].

***(b) Current practices in cost shifting between levels of government for medical services, including the MBS, pharmaceutical costs, outpatient clinics, aged and community care, therapeutic goods and the use of hospital emergency services for primary care;***

Australia has developed an ad hoc fee- for-service dominated model of maternity care rather than one led by outcomes and driven by research evidence. The consequence is rapidly escalating costs and accelerating cost shifting between State and Commonwealth as the consequences are felt within both systems. There is no overarching system to monitor these costs or align them with best practice evidence, or link outcomes of current models of care according to morbidity data. For example, the total Medicare benefit paid for obstetric ultrasound (MBS category 5, diagnostic imaging, item numbers 55040 and 55041) for the financial year 97-98 was $34,888,421 (HIC 1999). This accounts for more than half again of the entire obstetric Medicare rebate; $54,865,447 for the same financial year (Medicare tables 1999). Routine ultrasound in early pregnancy may enable better gestational age assessment, earlier detection of multiple pregnancies and earlier detection of clinically unsuspected fetal malformation at a time when termination of pregnancy is possible. However the benefits for other substantive outcomes are less clear (Neilson 1999). Given that ultrasound has never been proven either safe or effective in reducing infant mortality or morbidity (Pearson 1994), this is a questionable health cost to the nation. Examples such as these, of very high non-maternity costs encompassed in a maternity budget, unrelated to improved outcomes in a healthy pregnancy are increasing.

The Health Insurance Commission figures show a percentage rise of 89.4% in benefits paid for obstetric services for the years 1994-95 and 1995-96. This was in part due to the change in classification within the MBS to remove antenatal attendances from the global confinement and postnatal care item and list them as separate services (see former MBS item 16517). With these services being separated out and individually claimed from the 1st of November 1995, the costs of antenatal care appeared to increase dramatically (hence the 89.4% increase in the overall obstetric budget), when in fact the provision of obstetric care as a whole did not alter.

One of the unfortunate legacies of the funding systems bias towards bed day funding is the relative underdevelopment of non-inpatient services. The challenge to meet evidence based improvement in maternity care within the 'casemix' model is to fund services that extend beyond the hospital bed and provide effective services in the community. At present there are disincentives for hospital services to provide what research evidence shows to be 'best care'. Midwives, most often salaried hospital staff, not only cost less on an hourly rate, but the indirect costs attached to interventionist care such as increased bed days and use of equipment and tests are reduced when they provide care to healthy women.

***(c) The impact on consumers of cost shifting practices, including charges, timeliness and quality of services;***

Current research into the high rates of obstetric intervention for otherwise 'low risk' women indicate a very large commitment of Commonwealth and State budgets on tertiary level

[3] The published results of this study can be found in: Homer CSE, ,Davis GK, Brodie P, Sheehan A, Barclay LM, Wills J, Chapman G. (2000) Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard hospital care *Br J Obstet Gynaecol*;108:16-22

maternity care amongst those who might least need such expensive medical support. These rates impact across all levels of the system, affecting resource usage at hospital level and fee for service costs at Commonwealth level.

The preliminary unpublished results of research being undertaken by the author shows that women who have private health insurance and are attended by private obstetricians have a much greater risk of having an instrumental or operative birth than those women who give birth in the public system and do not have health insurance. In particular a very 'low risk' population of primiparous women who were privately insured were found to have very high levels of maternal morbidity. These women had twice the rate of epidural anaesthesia for childbirth and were nearly twice as likely to have an emergency caesarean section. They were three times more likely to have an instrumental delivery, and twice as likely to have an episiotomy.[4]

Women were considered to be 'low risk' using a similar but not identical definition adopted by the Clinical Standards Advisory Group in the UK. (CSAG, 1991) to describe care of 'normal labour and delivery' (Middle and MacFarlane 1995). The subgroup of women were between 20 – 34 years of age, had no medical or obstetric complications, a single baby with cephalic presentation at birth within the 10th – 90th birth weight percentile; born at term (37 – 41 completed weeks gestation). Privately insured women were considered to be healthier and better nourished than women with no insurance. And yet only 17% of these privately insured women who were considered to be at the least risk of problems in childbirth had a spontaneous vaginal delivery.

Whilst it will not be possible to infer causality from this research data, there is a need to further investigate both the cause and the discrepancies in rates of operative intervention in what must otherwise be described as a healthy population of women.

Other research shows similar trends in the difference between privately insured women and those accessing the public system. According to the Australian Medical Workforce Committee report (AMWAC, 1998) obstetric procedures undertaken in the years 1995-96 were more likely to occur amongst women who were privately insured 73.4% compared to those who had no insurance 56.5% in the 24-35 year age group (AMWAC 1998).

The implications of this research demonstrate an urgent need to review the current funding of maternity services. The rates of surgical intervention at birth amongst a predictably healthy cohort of Australian women are alarmingly high compared to models of care where midwives practice autonomously in the care of women in childbirth (Olsen 1999,Guilliland 1998, Weigers 1997, Tew 1991,).

The 'impact' for consumers from birth outcomes such as these are concerning when they are considered in the context of the health of children and mothers in terms of lowered breast feeding rates (Rajan 1994), rising levels of postnatal unhappiness, rising repeat caesarean section rates, long term perineal morbidity and long term emotional problems (Fisher 1995, Hillan 1995, Creedy 1999,).

A recent meta-analysis by Olsen (1997) showed that the total number of complications, the frequency of fetal distress, the frequency of neonatal respiratory problems and the frequency of birth trauma were significantly and consistently lower in births attended by midwives. Other clinical research has been undertaken in this area and it demonstrates that women who are cared for by midwives have significantly fewer operative intervention than those who are not (Hueston et al 1993, Weigers et al 1997, MacDorman et al 1998, Renfew et al 1998). Similarly women who have continuous support in childbirth are less likely to need pain relief, operative vaginal delivery and augmentation (Hodnett 1999). Research indicates that an improvement in these outcomes has a 'snowball' effect in creating a beneficial effect on rates of breastfeeding (DiMatteo et al 1996) post natal unhappiness, and psychosocial trauma ( Reynolds 1997, Ryding 1998).

[4] The published results of this study can be found in: Roberts CL, Tracy S, Peat B. Rates for obstetric intervention among private and public patients in Australia: population based descriptive study [see editorial]. *BMJ* 2000; 321(7254): 137-41 http://bmj.com/cgi/content/abstract/321/7254/137.

Within the Medicare funding system, public hospital expenditure is capped. Although prices are controlled for general and specialist services there is less limitation on volume and hence a 'perverse incentive to over service'. The generally uncoordinated nature of the system allows for major deficiencies at this level, with patients moving from one professional to another (Leeder 1998).
As a group of Victorian researchers found recently, the lack of effective monitoring and economic evaluation following the rapid expansion of fragmented models of shared care made it extremely difficult to draw a clear plan of the services being provided in this area (Dawson et al 1999).
One area of absolute certainty however, is the model for homebirth. Homebirth saves the taxpayer money in that it uses none of the resources funded by State or Commonwealth health funds. In this respect the woman and her family are disadvantaged in that they do not qualify for any of the benefits of the health system. The onus falls entirely on the woman and her family to engage and pay the midwives who attend the birth. Some private health funds have agreed to privately insure women for homebirth, because they can see the cost saving when compared to an elective caesarean birth for example[5] (Sprague 1999).

***(d) Options for re-organising State and Commonwealth funding and service delivery responsibilities to remove duplication and the incentives for cost shifting to promote greater efficiency and better health care;***
***(e) How to better coordinate funding and services provided by different levels of government to ensure the appropriate care is provided through the whole episode of care, both in hospitals and the community;***

Our recommendations which follow draw on some of the more successful aspects of the funding reforms for maternity care in New Zealand, as well as some of the key issues raised around the most recent Health Care Agreements negotiations which occurred in 1998 in Australia.

According to one of the co-founders of the original Medicare agreement, part of the strategic response to the long-term solution to the funding of Australia's health will be found in structural reform rather than incremental change (Scotton 1999). He advocates a model of managed competition that is specifically designed to induce profound changes in provider arrangements, in the way they are paid, what they deliver and how they're structured (Scotton 1999). The equity objective remains a government function and is even more apparent today due to growing health costs, and widening gaps between those with income and those without, and requires governments to subsidise both health status and income. The structural problems according to Scotton and others, are the fragmentation of programs; payment incentives which not only lack incentives but in many cases involve perverse incentives; jurisdictional and functional overlap, and conflict between levels of government and between the private and public sector (Scotton 1999, Leeder 1998, Owens 1999).

Some of the features of Scotton's restructured model include Commonwealth payments (benefits, grants etc) taking the form of risk-related capitation payments to budget holders who then 'manage care' by purchasing services for their enrolled populations. In turn, service providers contract their services to budget holders. The private sector operates within the national system so that as well as universal coverage, people can sign up for extra options not covered in the basic package. A general framework would set out the different services offered with the package rather than individual items (Scotton 1999).

In an editorial in the BMJ, Chris Ham, the director of the Health Services Management Centre in Birmingham, argued that if the separation between funders and providers remains, it enables health authorities to concentrate on assessing the population's health needs and promoting public health unencumbered by the responsibility of running services: a similar situation could exist for hospitals. But above all, there is transparency in the use of resources and health authorities are able to hold providers accountable (Ham 1997). A 'mosaic' of primary led models which include single practice fund holding and collective fund holding leads to innovative and entrepreneurial professionals seeking ways to improve health care.

[5] This service has been entirely withdrawn due to the lack of available Professional Indemnity insurance cover for Independently Practicing Midwives (IPMs) since May 2002

According to Ham, performance would be improved in several ways; by setting clear targets and measuring performance against these; by contesting and comparing quality outcomes rather than just cost and activity (Ham 1997).

The latest reform to the New Zealand system underlines this new approach. Having turned their backs on competition, countries such as The UK, Sweden, the Netherlands and New Zealand have stressed the need to focus on achieving health outcomes and improving the health status of the population: developing an approach based on family health teams for delivering some primary care services. “The importance of integrated care is being emphasised as both politicians and health professionals recognise the need for team working and co-ordination of delivery of services after a period in which competition has militated against such an approach” (Ham 1997p1845)

Increasingly funding bodies and consumers are calling for evidence to demonstrate the effectiveness of health services and the need for health care is both increasing and changing. Organisations and people need to become increasingly interdependent, willing to question existing values and beliefs in order to adapt to change. Public sector health care organisations have a particular need for an external orientation to identify new ways of doing more with less while maintaining quality standards (Perkins and Powell, 1999)

In Australia, case studies have been set up to pilot purchaser-provider models of community health service delivery and the move towards output, outcome based funding has emphasised this requirement ( ACT Community Care; Nancarrow 1999). Specifically these case study frameworks look at the inter-relationships between the following variables; intervention specific outcomes, adverse events, variation in the number of interventions, client satisfaction, cost, provider satisfaction, appropriateness of care and quality of life outcomes (Nancarrow 1999).

Another purchaser- provider model of funding exists in Western Australia. Community Midwifery WA is an incorporated organisation and receives Commonwealth funding (under the Alternative Birthing Services grant) that it uses to fund and support a group of midwives in the Community Based Midwifery Program. These midwives offer community care to women through pregnancy and birth. In the surveys used to monitor the program, the results so far are extremely positive (Reibel 1999)[6].

The funding of maternity care in New Zealand follows a remarkably similar set of principles. The funding is based on a prospective maternity benefit funding package legislated by the Health and Disability Service Act (1993) or Section 51 as it is commonly known. This is an agreed national contract outlining service specifications and payments for doctors, obstetricians and midwives. Under this contract the principal service provider known as the Lead Maternity Carer (LMC) claims the Maternity Schedule and is then responsible for payments to allied specialist referral services as needed. Maternity services have undergone a monumental shift in focus as the reform positions the service within a wider social policy context. All women have access to a universal maternity allowance that funds the caregiver of their choice for the period of their pregnancy, birth and month following birth. Care is undertaken in the community to a large extent, freeing up acute hospital facilities in many main centres.
The New Zealand College of Midwives (NZCOM) set up its own independent practice association called a Maternity and Midwifery Provider Organisation (MMPO). This is a commercial contracting body for midwifery members of the College[7]. It is the first non-medical health provider organisation and as such is in a strong position to tender and compete for the midwifery service contracts to ensure midwives offer a comprehensive service based on wellness and personal responsibility (Guilliland 1999). The MMPO is organised along the lines of an Independent Practitioner Association (IPA). These associations were initially formed by General Practitioners to provide a stronger contracting base to negotiate with government purchasing agencies in New Zealand, (similar in some respects to the Divisions

[6] Further information on the WACMP can be accessed from Reibel T (1999) Senate Inquiry into Childbirth Procedures; Senate references Community Affairs Hansard, Perth, 8th September 1999: CA 314-320 http://www.aph.gov.au/hansard; and more recently, http://communitymidwifery.iinet.net.au/
[7] Since the restructuring of the New Zealand Health System in 2000, the MMPO is negotiating a new and wider role in 2003, pursuant to Section 88 of the New Zealand Public Health & Disability Act, 2000, effective from July 1, 2002.

of general practice which exist in Australia.) (Malcolm 1999). In particular, the IPA's that formed on the initiative of practitioners, and without government mandate or sponsorship are reshaping the face of primary care. Their new roles include co-ordinating services, developing relationships with communities and other primary and secondary care services. They are moving rapidly towards clinical governance in primary care (Malcolm 1999).

*A suggested model: evidence based and women focussed*

There is much debate about the 'way forward' in Australia. The notion that hospitals or groups of salaried providers can tender to provide services within a capped budget is already with us in Victoria in relation to community based health services. A collaborative approach, incorporating the principles of 'integrated care', could bring together hospital salaried staff, midwives and staff specialists linked to General Practitioners and child health nurses. They would be grouped in community based teams to provide 'bundles' of services for publicly insured families across pregnancy, birth, post partum and infancy, to at least completion of first immunisations. This arrangement proposes an Australian 'maternity service' based on co-operation and information sharing, an emphasis on best practice for women; as distinct from the current provider driven and centred obstetric, or shared care models. These services would be provided within a capped fee that would cover the care that research describes as necessary and desirable for the health of women and their infants. There would be incentives in such a scheme, ie the funding 'cap', to reduce over servicing and employ the most cost effective and proven patterns of care and practitioner input to achieve optimal outcomes. Services could be set up to serve geographical and population 'catchment' areas. These would be resourced to meet both the socio-demographic and cultural needs of the communities served; and the practitioner mix arrangements that exist within state or territories.

Maternity service 'providers' that received funding would link tertiary referral and specialist services such as obstetric and neonatal high risk services into a continuum of care that crosses traditional community and hospital barriers. (Our team has proposed a similar model for organisation of services [not funding] in South Australia at the request of the government. It is currently being adopted as the model for metropolitan Adelaide ( Barclay & Brodie 1999). The state government has had to adopt this approach because of an unjustified proliferation of specialist medical services and hospitals which can no longer be defended or afforded within the health system in that state). In such a model, replicated on a larger scale, fees could be based and outcomes measured on the requirements of healthy women and infants rather than fee for service

This proposal requires thorough economic analysis and far more complicated planning and assessment that we can provide in this brief paper or that we have sufficient skills to complete. However it does seem that proposals such as these have merit and would be of benefit to governments whose funding is out of control and demonstrates a lack of rationality in relation to these services.

We intend to adapt a model proposed originally by the Australian Healthcare Association (Smith 1998), to demonstrate where we see maternity services placed in the Australian system of revised funding This will be submitted at a later date.

New models of maternity care will require cooperation between Commonwealth and State funding systems to 'bundle' fees for the full range of services into a capped package service. The consequence of not collaborating is extensive cost shifting that is occurring now and reducing the quality of care for women (Lumley and Brown 1998). Each district would design a package of services and mix of practitioners to provide the best care possible within the 'capped' fee and would have to argue a 'special needs case' to vary this. Exceptions to health, ie when clinical problems arise, would be funded on top of the 'cap' for tests and other services that become necessary if problems arise and referral necessary. The woman and her infant would remain with the supportive care of either her midwife, general practitioner or early childhood nurse who would continue to provide continuity of care and support alongside any specialist intervention required for the mother and or infant. Specialist care would be provided and reimbursed only as necessary and not replace routine or 'normal' care that can be provided more cost effectively and satisfyingly by other practitioners. "Increased accountability of the hospital as a whole will lead to increased demands for accountability of

medical staff. Tighter organisational forms, which link the medical staff more closely with the hospital rather than see them as 'visitors' will become the norm" (Duckett, 1997 p22).

Continuity of community oriented midwifery care, as an outreach service of hospitals providing birthing services, can provide the bridge between community and hospital. Such a system has been integrated into mainstream care at St George Hospital, Sydney, and very carefully evaluated. It would operate more economically and effectively if some of the current funding anomalies were removed.

Where 'team' and 'caseload' midwifery models have been implemented the outcomes suggest they are of benefit to women and babies (Kenny 1994, Rowley 1995, Homer 1999, Leap 1999, Reibel 1999). At present a number of these models are being stopped in NSW. It appears to be expedient, easier, and less politically difficult to do this rather than reduce Visiting Medical Officer costs or to grapple with overuse of operative interventions or technology. Until remuneration encourages non intervention by provider, probably through some form of capped prospective allowance for each woman attended, mothers and babies will continue to be disadvantaged by not having access to proven practices of safety and comfort in childbirth. It goes without saying that this system must also allow specialist care to be incorporated when necessary,

***(h) The adequacy of current procedures for the collection and analysis of data relating to public hospital services, including allied health services, standards of care, waiting times for elective surgery, quality of care and health outcomes; and***
***(i) The effectiveness of quality improvement programs to reduce the frequency of adverse events.***

With the introduction of a capped prospective maternity benefit, we recommend the introduction of an advanced data retrieval system in order to evaluate outcomes and costs in relation to maternity care. These initial systems are in place nationally, although the data retrieved is not uniform across all States and territories (Lancaster 1999). There is room to improve on the capture of routine data with the addition of fields to capture more comprehensive information on economic outcome measures. Evaluation of maternity care in particular needs to consider both the value of health interventions to the wider population, and the value of the expected outcomes of the intervention to the individual. Data fields for economic evaluation can be designed to respond to the growing need to recognise both the value of the intervention to the individual and to society at large (Viney 1999). At present the information contained in the Midwives Data Collection is available to a select few epidemiologists who are not funded to provide descriptive analysis on a routine basis. Such analysis requires to be undertaken by highly qualified and skilled people in order to provide accurate data, which is then accessible to funders of services and the public.

The Midwives Data Collection has the potential to become a valuable tool for informing both women and practitioners about the results of practice. We would advocate a further development of this valuable resource along the lines of the Health Care Cost Utilization Project (HCUPnet); an interactive tool for identifying, tracking and analysing national hospital statistics based on data from a Nationwide Inpatient Sample in the USA). This project was established as part of the Agency for Health Care Policy and Research (HCPR 1999).

Regulators in the United States and New Zealand have looked into statutory codes of rights as a mechanism to protect consumers enrolling in health plans and patients receiving health care. Strengthening the hand of 'patients', by ensuring access to accurate relevant, and understandable information abut quality, has been identified as key strategy for improving the quality of health care (Paterson 1999). Such initiatives would address the key mission statement of the newly formed Australian Consumer Focus Collaboration. This states, "the collaboration will work with key stakeholders to promote, integrate and disseminate information and initiatives which increase consumer involvement in health service planning, delivery, monitoring and evaluation at all levels in a dynamic and responsive way" (Consumer Focus Collaboration Mission Statement, August 1998)

CONCLUSION

The focus for maternity care is the woman and her family.

In our complex health system today, very often the most fundamental needs are not met. The woman and her family pass through the hands of an assembly line of strangers where care is organised as though the childbearing woman is ill, and the care of obstetricians, highly trained specialists in surgery and complicated birth, is substituted for the skills of midwifery (Page 1995).
In order to address this mismatch between what women want from a service, and what the service is able to deliver, we recommend a major overhaul of the funding of maternity care in Australia.
A balance will be achieved through greater recognition of the skills of the midwife, and the funding of maternity services where the practice of midwifery is a valued component of an integrated maternity care workforce, with its primary focus, the care of the childbearing woman.

**RECOMMENDATIONS**

1) We recommend an evidence-based approach to the provision of public hospital maternity care. This would involve mainstreaming the models of continuity of midwifery care that up to this point have mainly been considered 'experimental'.
2) We recommend a review of current funding models tied to practices that are unnecessarily interventionist and not evidence-based.
3) We recommend that both Commonwealth and State governments review the funding mechanisms that govern the provision of maternity care in Australia in order to promote community orientated midwifery care

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## SENATE INQUIRY INTO NURSING[1]

The following paper is based on the AMAP Submission to the Senate Community Affairs References Committee INQUIRY INTO NURSING, June 2001[2].

Terms of reference

a) The **shortage** of nurses (and midwives) in Australia and the impact that this is having on the delivery of health and aged care services.
b) Opportunities to improve current arrangements for the **education and training** of nurses (and midwives) encompassing enrolled, registered and postgraduate nurses (and midwives).
   i. nurses (and midwifery) education and training to meet future labour force needs
   ii. the interface between universities and the health system
   iii. strategies to retain nurses (and midwives) in the workforce and to attract nurses (and midwives) back into the profession(s) including the aged care sector and regional areas
   iv. options to make a nursing (or midwifery) career more family friendly
   v. strategies to improve occupational health and safety

This submission is based on a paper published in *the Australian Health Review* in November 2000 Tracy S, Barclay L, Brodie P. Contemporary issues in the workforce and education of Australian midwives. *Australian Health Review*. 2000:23(4);78-88
It has been updated and abridged for the purpose of this submission.

KEY ISSUES

The key overriding factors that influence our current crisis in the shortage of midwives and problems with midwifery education:

- Firstly, there is an urgent need to increase the number of midwives. The shortage of midwives is a global problem and Australia can no longer rely on migration from other countries to correct the serious shortfall
- Secondly, there is a serious lack of culturally appropriate midwifery training at tertiary level. The tension to be addressed in Australian higher education is, 'what is the balance between Indigenous peoples' desires for autonomy and self-determination and the overall institutional commitment to ensuring that those efforts are realised within the federated structures of universities' (Anderson et al 1998 p 9).
- Thirdly there needs to be both retention and recruitment of midwives through more attractive working conditions. Midwifery models based on evidence of safety and cost effectiveness promoting communication and co-ordination between health care professionals, linking hospital and community care. They are more clearly focussed in primary health care rather than hospital illness or trauma.
- A revision of the funding of midwives is required to reflect a primary health model where midwives practice across the interface of community and acute care setting. This would promote continuity and collaboration between providers of antenatal, birth and postnatal care and strengthen support for evidence-based models of maternity care. A public health model of care does not necessarily reward tertiary surgical care for all women in childbirth but recognises and funds the wider contribution of midwives within the health sector.
- The education of midwives through pre-registration undergraduate degree programs should be initiated at the first possible opportunity. It may take five years and considerable cost to the student and the university, to produce a beginning practitioner through our postgraduate educational pathways, Midwives educated through pre-registration undergraduate degree programs with a social/family-oriented approach to care would practice in collaboration with medical colleagues and other health providers, in all aspects of maternity care. Already there is a substantial 'waiting list' of prospective students eager to enrol in the new Bachelor of Midwifery program (Leap, 2000) and South Australia, New South Wales and Victoria are poised to begin undergraduate midwifery education programs.
- A system that provides Indigenous communities with their own midwives could contribute significantly to improving perinatal health care for mothers and their infants.

[1] The final report can be found at Commonwealth of Australia 2002. Senate Community Affairs Committee THE PATIENT PROFESSION: TIME FOR ACTION. Report on the Inquiry into Nursing JUNE 2002. http://www.aph.gov.au/senate/committee/clac_ctte/nursing/index.htm

[2] This submission represented the views of the following members of the research team and the Centre of Family Health and Midwifery, UTS, Sydney. Professor Lesley Barclay, Sally Tracy, Pat Brodie. The submission was endorsed by the Faculty of Nursing Midwifery and Health, UTS, Sydney; Women's Hospitals Australasia, and the Australian College of Midwives Inc.

Such an initiative would reduce the social disruption to remote area women who are transported hundreds of miles to give birth to their infants.

- A national database of the midwifery workforce is a prerequisite to careful and judicious planning of the midwifery workforce. It will allow all concerned to monitor trends and predict supply.

**Introduction**

The practice of midwifery is integral to the care of women in childbirth. In Australia during 1998 there were 253,771live births, the majority of which (99.7%) occurred within the hospital setting (Nassar 2000). Since 1984 the infant mortality rate has almost halved from 9.24 deaths per 1,000 live births to 5.86 in 1994 for non-Indigenous mothers. However it remains nearly double that rate for Indigenous women (AIHW 1998). In the past six years the perinatal death rates per 1,000 births has not altered significantly, 1993 – 9.2 per 1,000 births to 8.3 per 1,000 births in 1998 (Nassar 2000). However it remains nearly double that rate for Indigenous people. (AIHW 1998).

Over the decade 1984-1994 the overall fertility rate remained stable at 2.1. The latest figures show this has dropped, however, to 1.76 for non-Indigenous women in 1998 (a figure slightly higher than some European countries), and remains at 2.2 for Indigenous women (AIHW 1998). The population projections of the Australian Bureau of Statistics show that the fertility rate could fall to 1.75 in the years 2005-6, but should remain constant at that rate (ABS 1999).

Population projections demonstrate a continuing need for maternity care that is dependent on various levels of skill and expertise. Australia's high standards of maternity care assume the presence of qualified midwives who offer safety and support for women in childbirth and the puerperium in collaboration with medical colleagues, and increasingly as alternative providers (AMWAC 1998). The shortage of registered midwives will inevitably impact on the quality of care provided in maternity services.

**a) Shortage of midwives**

The availability of data on the midwifery labour force is one of the most pressing issues. The capacity to draw meaningful conclusions is compromised because of the use of **non-standardised terminology** and the incompatibility of databases and data domains (NSW Health 2000). The Australian Medical Workforce Advisory Committee (AMWAC) recently published its study of the supply and requirements of the obstetric and gynaecology medical workforce in Australia (AMWAC 1998). It attempted, but had difficulty in providing baseline data on midwives for this study. All States and Territories who responded indicated that there was an under supply of midwives. However, Victoria, South Australia and Queensland were unable to respond. (AMWAC 1998). As in other nursing workforce publications, the AMWAC study data does not differentiate between enrolled and registered nurses working in midwifery and obstetrics in Australia.

In Australia, a midwife is a specialist in the field of midwifery, who has gained a general nursing qualification (about three years) and then post graduate qualifications to enable her to register as a certified midwife (one to three years – depending on what course she takes.) The data specific to the profile of midwives showed that in 1995, 99.0% of the midwifery workforce were female, 25% of midwives were aged between 35 – 39 years, 65.5% of midwives are aged over 35 years.

Data that was *not* specific to midwives showed that in 1995, 74.1% of nurses employed as clinicians in midwifery and obstetrics were based in capital cities, 23.9% were located in rural areas and 1.9% were in remote areas.

A more complete picture of the midwifery work force was derived from all available sources of published data, including the AMWAC Report 1998.

Table 1 illustrates the numbers and average ages of registered and practising midwives by State and Territory; the vacancies known to exist, and in some cases the students needed to maintain the workforce. It is drawn from several referenced sources and by combining available published data it provides a representational overview of the situation. It is not a quantitative measure of the current workforce and should be viewed only as a crude estimate.

**Table 1.** Available data to illustrate numbers and average ages of registered and practising midwives by State /Territory in Australia 1995-1999

| | NSW | VIC | QLD | WA | SA | TAS | ACT | NT |
|---|---|---|---|---|---|---|---|---|
| #Births | ***86,263*** | ***62,732*** | ***47,864*** | ***25.090*** | ***19,310*** | ***6,682*** | ***4,830*** | ***3,607*** |
| Registered Midwives | **ϕ10,400** | ***13,347** | **♣ 8,125** | **ϕ2,814** | **♦** | ***870** | **♦** | **♦** |
| Practising Midwifery | **ϕ3,044** | **† 3,566** | **♣ 2,600** | **ϕ 931** | **§1521** | **ϕ357** | **±343** | **ϕ167** |
| Vacancies | **ϕ 90** | **♦** | **♣ 128** | **ϕ66** | **♦** | **♦** | **♦** | **ϕ37** |
| Average Age | **ϕ35-39** | ****40-49** | **♣ 41** | **ϕ42.7** | **§40** | **ϕ45** | **♦** | **♦** |
| Students needed | **ϕ 320** | **♦** | **♣180 –200** | **ϕ70** | **§109** | **♦** | **♦** | **♦** |

*Sources;* # AIHW 1998; ± AIHW 1999 *Nursing Labour force 1998;* ϕ AMWAC Report 1998; ♣Qld Health 1998 Midwifery *Workforce Planning for Queensland;* ** ACMI 1999 *Reforming Midwifery;* ***Nurses Board of Victoria Annual Report 1998; † Victoria Department of Human Services 1999 *Nurse Labour force Projections Victoria 1998-2009;* § Rawinski et al South *Australian midwifery training Requirements 1997-2001;* * ACMI (Tas) 2000; ♦ Data unavailable

The Australian Institute of Health and Welfare report, "Nursing Labour Force, 1993 and 1994" showed that the proportion of nurses aged less than 25 years had declined from 33.3% in 1981 to 6.0% in 1994 (AIHW 1995).

Watson et al found that nurses were five times more likely to be in their twenties than midwives - 26% compared to 5% (Watson et al 1999). The study of 240 practising midwives in Victoria found that at least half of those in full time employment were over 40 years (Watson et al 1999).

The recently completed "NSW New Graduate Study" reports that 30% of newly qualified midwives did not seek midwifery related employment on graduation (NSW Health 2000).
The information held by the state Nurses registration boards pertaining to actual numbers of registered midwives and practising midwives is collected for the Australian Institute of Health and Welfare and is not freely or publicly available.
The difficulty with all published data is that it is not possible to separate out those nurses who are enrolled nurses practising in the area of obstetrics and maternity nursing, those who are registered nurses practising obstetrics and those who are registered or certified midwives practising midwifery.

**Calculating the numbers of midwives needed using a rudimentary model.**

Currently there are 3,000 midwives who are members of the Australian College of Midwives Inc., and the College believes their membership to be approximately 30% of all practising midwives. This estimate suggests there could be possibly 9 – 10,000 midwives at present in Australia, a significant number of whom are employed on a part time basis, who report their main area of work as 'midwifery practice'.

A projection of the number of full time equivalent midwife positions needed in Australia is based on the known statistic of 249,600 live births (AIHW, 1999). Allowing for one full time midwife in practice per 40 births, the estimated number of full time practising midwives needed to provide services for these women alone would be around 6,500. A number of midwives are also employed where their midwifery knowledge and skills are necessary, in teaching, neonatology, gynaecology, women's health, early childhood services, family planning and research. In addition, a group will move into leadership through management positions.

We undertook a rudimentary modelling exercise, which built in attrition rates of 10% and part time employment based on 25% of the workforce. The attrition rate is lower than the 30% attrition rate found in "The New Graduate Midwives Survey" undertaken by the NSW Health Department (NSW Health 2000). The part-time estimate is also more conservative than figures from the nursing workforce data showing only 42.9% of registered nurses employed in midwifery, obstetrics and gynaecology were working full time (AIHW, 1999); or the AMWAC Report 1998 showing only 47.0% were working 35 hours or more; or a recent study of practising midwives in Victoria showing only 27% in full time work and 73% in part-time employment. (Watson et al 1999).

We based our calculations on the need for 8,558 midwives just for direct clinical midwifery care (excluding gynaecology and obstetric nursing). This figure agrees broadly with some of the other estimates that were made using New South Wales's specific data (NSW DOH, 1996). We estimate we are currently educating about five hundred and fifty (550) student midwives in Australia. This is based on estimates of 22 pre-registration programs with an average of 25 students in each course (AMAP figures 1999).

Using a conservative estimate of 10% of the current workforce needing to be educated annually to maintain a steady supply, and 10% more needed to cover attrition, and assuming 8,558 midwives are needed to fulfil the needs of clinical services, the number of students required in programs today would be around nine hundred and forty (940). Our conservative, 'best estimate' suggests we are currently educating 550 students, which is less than two-thirds of the number required. The recently released "New Graduate Midwives Survey" confirms that 'the pool of new graduate midwives supplying the midwifery workforce is considerably less than the predicted numbers required to adequately sustain the workforce' (NSW Health 2000 p 7).

There are further complications in basing estimates on student numbers because of the difficulty in separating out overseas students from those who intend to work in Australia. We cannot determine the actual number of overseas fee paying students in midwifery programs at present, although we know that 46.4% of students commencing post-basic nursing courses in 1998 were overseas students (AIHW, 1999).

**Issues in rural Australia and in particular concerning Indigenous midwives**

Rural and remote Australian women are suffering most as a result of shortages of midwives according to health service leaders and Government figures showing regional skill shortages (Serghi 1998). Where maternity services have been closed down it is socially disruptive, expensive and distressing for Anglo Australian women to travel great distances to larger centres. However, the results for Indigenous Australians show up even more starkly in statistics. Data on the health of Indigenous mothers and babies demonstrate a crisis in providing acceptable services for these people. Although there have been reductions in infant and maternal mortality among Indigenous people, the differential in birth outcomes between the Indigenous population and other Australians has not been eliminated. The proportion of low birthweight babies (under 2500 grams) born to Indigenous women has remained two to three times higher than for non-Indigenous women (ABS 1997, AIHW 1998). Similarly the stillbirth rate and the death rate for babies in the first 28 days of life are two to four times higher (AIHW 1998). In the Northern Territory the perinatal mortality rate for normal birthweight babies of Indigenous mothers is 20 times greater than that of babies of non-Indigenous mothers (Markey et al 1996). Other States also report alarming differences in

perinatal mortality rates between Indigenous and non-Indigenous people (ABS 1997, Crowley 2000).

Three of the most recent reports on health and birthing services available to Indigenous women draw consistent conclusions and make similar recommendations (Kildea 1999, Hecker 2000, Standing Committee on Family and Community Affairs 1999). They include:

- ⊕ an acute shortage of midwives and inadequate numbers of Indigenous people training to become health workers and health professionals. Although more than 40% of Indigenous people live in either rural or remote areas of Australia (AIHW 1998), 42.1% of nurses employed in these areas are enrolled nurses compared with 26.8% registered nurses. (AIHW, 1999).
- ⊕ a lack of educational opportunity for Indigenous health workers and maternal and child health workers to be educated as midwives (Kildea, 1999, Hecker 2000).
- ⊕ a need to build better links between Aboriginal women, support people and labouring women (Kildea 1999, Hecker 2000).

Nearly 30% of Indigenous mothers from remote communities have to travel away from their home location to give birth (Markey et al, 1996). This is not a problem in some places where cultural needs are fully met (Brodie 2000). However, for many women the loneliness of the separation from families, and the fear of strange surroundings are overwhelming. Many Aboriginal people fear that if they give birth somewhere other than on their homeland they may relinquish rights of traditional ownership (Kildea 1999).

### b) Opportunities to improve current arrangements for the education and training of nurses (and midwives) to meet future labour force needs

#### Regional and remote issues

Both the cultural and financial barriers to the training and education of Indigenous midwives are significant. The cost, duration and geographic location of the present midwifery training programs disproportionately disadvantage Indigenous women. There is a need to create a space from where efforts can be made to reflect and entrench Indigenous values and protocols across all sectors of the university. No doubt this raises questions about making fundamental changes to the core values and ethos of the university so as to ensure that Indigenous knowledges and Indigenous ways of relating, seeing and doing are included and given legitimacy. This is not only about inclusion, it is also about acknowledging the sovereignty of Indigenous peoples' (Anderson et al 1998 p4).

The discussion paper from a recent Inquiry into Indigenous Health suggests that 'a vertically integrated system for the recruitment, education and training of rural and remote health professionals should be developed, based on the collaboration of governments and training institutions' (Standing Committee on Family and Community Affairs 1999 p20). Similarly, a report on equity issues and universities' inclusion of Indigenous Peoples' rights and interests, funded by the Commonwealth government, recommended that 'universities need to accommodate Indigenous interests and rights across all facets of their operations—teaching, research, administration and community service. This requires more than cross-cultural awareness training, the incorporation of Indigenous perspectives in the curriculum or the employment of Indigenous educators.

#### The expense of midwifery education: the HECS

In 1996 the Higher Education Contribution Scheme (HECS) was altered and full fee charges were levied for the first time for postgraduate education. Midwifery is classified as a postgraduate qualification and therefore it now attracts full course fees. This places a considerable personal financial burden on nurses who wish to study midwifery, and affects both the recruitment and attrition rates of Australian students..

In 1999 only 19-21% of students entering Band 1 (nursing, education) were from low socio-economic groups (Andrews, 1999). Disciplines were placed into differential HECS bands

according to the cost of the course and on the average earning potential of graduates from those disciplines. Nursing was grouped with arts and education in HECS Band 1 with a $3,300 contribution.

The level of (mature age) applicants from those entering higher education did not appear to have been affected by the introduction of HECS in 1989.
However the subsequent changes in HECS funding (1997) has affected an estimated fall of 10,000 persons or 10 per cent of mature age applicants (Andrews 1997 p 33). This falll has not been affected by the level of unsatisfied demand in the work place (Andrews 1997).

The participation of women in higher degrees increased steadily over recent years within HECS funded courses. The gains made by women in the postgraduate sector are tenuous because of the trend to reduce such courses (DETYA, 1999).

Many women and students from Indigenous and/or rural and isolated backgrounds are already either not making it into postgraduate study or facing financial hardship following further education (DETYA 1999).

Research conducted by the Council of Australian Postgraduate Associations (CAPA) found that women in female dominated professions feel particularly disadvantaged by up-front fees where a relatively low level of employer support combined with low incomes pose serious equity problems (CAPA 1999).

**Current attrition rates in midwifery education**

Although there are no published data specific to attrition rates within midwifery courses, Table 2 is derived from several tables showing completion rates of Australian students entering nursing education (AIHW 1999 pp. 20-23).

**Table 2**. Percentage of Australian (permanent resident) students completing the basic and postgraduate courses in nursing in Australia from 1994-97.

| COURSE | ENROL 1994 | COMMENCE 1994 | ENROL 1995 | COMMENCE 1995 | COMPLETE 1997 (%) |
|---|---|---|---|---|---|
| **3 YR Basic Nursing** | 23,629 | 8277 | | | 5,323 (64.05) |
| **Grad. Certificate** | - | - | 321 | 301 | 324 (100.0) |
| **Grad. Diploma** | | | 2641 | 1843 | 1622 (88.0) |
| **MA +** | - | - | 1217 | 637 | 298 (46.0) |

*Source: Nursing labour Force 1998, AIHW 1999*

*The addition of 23 in the Grad.Cert. course could correspond to those who were enrolled in a Masters course, but subsequently left to complete a Grad.Cert.*

Reliable anecdotal reports from universities in New South Wales suggest attrition rates in some midwifery programs are as high as 50%, enrolments in some programs as low as 50% and overseas students may fill up to 25% or more of the postgraduate midwifery places in some programs. The current competitive climate makes this sort of sensitive information difficult to verify.

**Inconsistencies within midwifery education**

There are a number of post basic midwifery courses on offer in the universities of Australia. It is apparent there is no overall consistency in design, duration or level of award both nationally or within each separate state.

The ACMI advises that current preparation for practice should be at graduate diploma level.

At present there is no national monitoring system to guarantee comparability or an adequate baseline of competence. Not all states and territories have adopted the current ACMI midwifery competencies (NSW Health 2000).

**Strategies to address the labour force shortfall through midwifery education**

1. Remove the postgraduate fee attached to midwifery education. Preliminary research suggests this is a major barrier for registered nurses.
2. A three-year Bachelor of Midwifery (B Mid) or undergraduate midwifery degree program without the pre –requisite three-year nursing registration.
3. A specialist degree course in midwifery in line with International trends in other western countries eg . The Netherlands, France, Denmark and Canada offer midwifery education only and not as an 'end on' to nursing. In each of these countries undergraduate education to degree level for midwives is considered standard practice. The UK and New Zealand prepare the majority of midwives in comprehensive three-year undergraduate degree programs and plan to close postgraduate nursing midwifery courses in favour of the direct entry model (DOH 1998, Pairman 2000).

**An undergraduate degree program in Midwifery - Bachelor of Midwifery (BMid)**

A proposed undergraduate degree program in Midwifery (direct entry midwifery) is one way to address issues of cost in postgraduate training of midwives. It will produce graduates in three rather than five plus years and will not attract current postgraduate fees. In countries other than Australia, where the Bachelor of Midwifery is the preferred education model for midwives, course enrolments are at full capacity while attrition rates have fallen significantly. (Page 2000, Pairman 2000).

The Victorian branch of the Australian College of Midwives in collaboration with women and consumers paved the way for public discussion with their release of a comprehensive discussion paper called "Reforming Midwifery" (ACMI Vic. 1999).

A meeting was called in Adelaide in December 1999, to 'launch' the BMid. All interested universities were represented in the initial working party to consider the philosophical, professional, strategic, educational and financial gains to be had by launching the first Bachelor of Midwifery courses simultaneously. There was a unanimous vote to proceed in a unified manner to establish national guidelines for the new midwifery education. It was also agreed the standards would be implemented in partnership with the regulatory authorities.

Following this meeting the Australian College of Midwives released the following press statement on the 28th April 2000. "An ACMI Taskforce composed of midwifery educators from each state and territory has been formed to oversee the development of consensus guidelines that will form a national framework for the introduction of Bachelor of Midwifery education programs across Australia. This national framework will establish and articulate professional standards for the accreditation of the three-year Australian Bachelor of Midwifery (BMid) programs. These programs will enable graduates to practise competently in a range of settings within the full scope of practice defined by the International College of Midwives. The purpose of the national framework is to establish and articulate professional standards for the accreditation of Bachelor of Midwifery (BMid) programs that will proceed with the support of the Australian College of Midwives" (ACMI 2000).

The process of accreditation for the undergraduate degree in midwifery has begun in all states, with the regulatory bodies being approached to endorse standards, preparatory to full licensing of the undergraduate degree.
The Commonwealth has also been approached with the initial discussions with DETYA occurring in Canberra on the 22nd May, 2001.
As part of the current project , during the first half of 2001, the researchers from the Australian Midwifery Action Project held consultations to discuss recent developments in midwifery with the Australian Nursing Federation, the Australasian college of Obstetricians and Gynaecologists, the Australian College of Nursing and the Chief Nurses of Australia.

The professional and political environment has to support the need for urgent action on the midwifery component of our maternity care workforce. In Australia we cannot continue to operate in professional isolation and risk the consequences of remaining out of step with the developments of our profession internationally.
The recent licensing of a number of overseas-educated 'direct entry' midwives in a number of Australian states has forged the route for registration for pre-registration, undergraduate degree midwifery students. To highlight some of the discrepancies occurring at present, overseas educated midwives who are not trained as nurses are required to register as 'nurses' to work as midwives. This assumes some competency in nursing for which they have no educational preparation.

**The interface between universities and the health system**

Any changes in the current situation must consider the economics of a contracting funding base for the university sector. Nursing education, and by inference, midwifery education, has a high cost factor and a relatively low earning potential (Andrews 1999). If midwifery undergraduate programs were introduced they would share core subject teaching across midwifery and health programs. For example pre-registration midwifery graduates could move into shortened general nursing pathways, and to post graduate education in either nursing or midwifery. The BMid program would educate midwives who can provide a breadth of practice across tertiary, remote and rural areas.

The needs of women who seek low intervention, midwifery models of maternity care also have to be considered. A recent Senate Inquiry in Australia found that the availability of birth centre facilities are so limited for women in many areas, they are required to submit to a 'ballot' system, or a lucky draw to gain access to these birthing facilities (Crowley 1999). New models of education for Indigenous midwives would begin to address the alarming problem of poor outcomes in maternity care for Indigenous women and their families (Hecker, 2000).

In order to meet changing community and workforce needs, higher education sectors, government and the nursing profession must take account of

- ⊕ changing nature of health care delivery within the Australian community;
- ⊕ emergence of new areas of nurse specialisation which meet the criteria given above for approval of nursing specialties;
- ⊕ future development/s of the role/s of nursing specialists;
- ⊕ demand by potential students in conjunction with workforce requirements (that is, market forces); and
- ⊕ appropriate spread of nursing specialist programs across Australia in terms of: demographic trends and geographical location' ( Russell et al 1997).

The "New Graduate Survey" recommends that Area Health Services work with universities to ensure that midwifery education programs meet service needs (NSW Health 2000).

**Retention of midwives**

Tensions exist between the primary health care model and the realities of midwifery services provided under acute care hospital budgets as …. 'In many cases services are not developed with sufficient attention to the expressed concerns of birthing women, population or epidemiological data' (NSW Health 2000 p25).

The preliminary findings from a national study into the barriers to midwifery care in Australia (AMAP) show that many of the midwives who responded believe midwives leave the maternity service disillusioned by the lack of recognition for their skills as midwives. They are made invisible by the over riding 'culture' of the acute services system and practical barriers to service organisation and budgets that prevent them practicing antenatally or postpartum care in the community (AMAP 2001). These findings are consistent with a recent public health report tabled in the UK House of Commons in March 2001 advising "midwives are often passed over by public health strategists because they are usually employed and managed by the acute sector, which is not at the forefront of the public health agenda".( Select Committee

on Health of the House of Commons). Two important exceptions exist within the maternity services in Australia at present, the St George Outreach Maternity Project (Homer et al 2001) and the Western Australian Community Birth Project ( Thorougood 2001).

Randomised controlled trials of midwifery care show:

- that midwives offering continuity of care gain a significant increase in autonomy and work satisfaction (Flint et al 1989, McCourt et al 1996, Turnbull et al 1996, Rowley et al 1996).
- that where midwives care for women through the entire antepartum, intrapartum and postpartum episode, the maternal and fetal outcomes have been found to be safe, less interventionist and more satisfying for both the woman and the midwife involved (Flint et al 1989, Hueston et al 1993, Kenny et al 1994, Rowley et al 1995, Turnbull et al 1996, Harvey et al 1996, McCourt et al 1996, Waldenstrom et al 1998, Guilliland et al 1998, McDorman & Singh 1998, Hodnet 1999, Homer et al 2001)

Continuity of care models encourage midwives to use their skills across community and hospital settings. Being based in the community provides a viable option for rural settings in Australia instead of the more costly 'roster based' system within hospitals. It encourages a greater emphasis on 'problem prevention' and health promotion through community-based antenatal and postnatal care. This model of midwifery care is ideally suited to outcome based funding as opposed to fee-for-service funding.

Workforce figures from the New Zealand Nursing Council show that nearly 40% of midwives carry a caseload. While New Zealand hospitals also report having difficulty recruiting non caseload (rostered) midwives, the number of self-employed midwives with caseloads continues to grow. (Nursing Council of New Zealand. Registered Nurses, Midwives and Enrolled Nurse Workforce Statistics 2000). These facts hold significance for Australia in terms of the Australian New Zealand Closer Economic Relations Trade Agreement (ANZCERTA) 1983 and the Trans Tasman Mutual Recognition Act 1997 that form the basis for reciprocal arrangements in the employment of midwives. Not only did Australia used to rely heavily on New Zealand 'imports' in nursing and midwifery, the growing disparity between the education of midwives in Australia and New Zealand will make it more and more difficult to recruit new Zealand midwives in Australia.

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**SUBMISSION TO THE NEW SOUTH WALES DEPARTMENT OF HEALTH. REVIEW OF THE NURSES ACT 1991[1]. October 1999**

Prepared by the Research Team of AMAP[2]

Professor Lesley Barclay

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Guiding Principles for Discussion

> "The guiding principles of the Competition Principles Agreement are that legislation is not to restrict competition unless the benefits to the community outweigh the costs and the objective of the legislation can only be met by restricting competition. The review has applied these guiding principles in assessing the restrictions outlined above and the alternatives raised in the Issues Paper." (NSW Health 2001[3])

The following submission is in two parts:

Part A - discuss in general the review of the Nurses Act 1991

Part B - address the safety of midwifery.

## PART A

### INTRODUCTION

The practice of midwifery in Australia is undergoing examination. This requires us to re examine the regulatory procedures governing the practice of midwifery. The review of the NSW Nurses Act 1991 has the potential to become an innovative and visionary article of legislation that could be a benchmark for changes in other Australian states.

Discussion Point 1.

The scope of market for midwifery services will be restricted only by the amendment of the title "midwife" and "midwifery" which does not include the pre-requisite qualification of "registered nurse". Only those who hold an approved qualification in midwifery may use the title "midwife", hold themselves out as capable of or willing to practise midwifery and engage in the practice of midwifery. This amendment addresses the future registration of midwives who will have completed an undergraduate degree in midwifery without first holding a nursing qualification.

Undergraduate degree programs for the education of midwives are being proposed in Australia at present (ACMI Victoria 1999)

This form of education is mainstream in New Zealand, UK, Netherlands, Canada and some states of the USA

Discussion Point 2.

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[1] The final report can be accessed at NSW Health. Report of the Review of the Nurses Act 1991, October 2001. www.health.nsw.gov.au/csd/llsb/nursereview/

[2] NB: this submission reflects the position of the three named investigators only

[3] See Report of Review 2001

Merging lists A and B on the register/roll can be safely achieved for nursing, where the board may be empowered to place conditions on practice in the form of a restricted title. This does not require a further definition of practice; it merely indicates the level of education of the nurse.

We recommend however, that the Nurses Registration Board should initiate a separate list C for the registration of midwives.

Discussion Point 3

### *Objectives of the Nurses Act*

Suggested revision of the Objectives of the Nurses Act are as follows:

10 (1)

a) to promote and maintain professional standards of nursing ***and midwifery practice*** in New South Wales.

b) to promote the education of nurses ***and midwives*** and educational programs relating to nursing ***and midwifery***,

c) to advise the Minister on matters relating to the registration and enrolment of nurses ***and midwives***, standards of nursing ***and midwifery*** practice and any other matter arising under or related to this Act or the regulations,

d) to publish and distribute information concerning this Act and the regulations to nurses, ***midwives*** and other interested persons.

e) to hold examinations for the purposes of this Act and to determine the character, subjects and conduct of those examinations

f) to appoint examiners and supervisors in respect of examinations referred to in paragraph (e)

g) to appoint places and times at which examinations referred to in paragraph (e) are to be held

h) for the purpose of facilitating under this Act the registration of nurses ***and midwives***, the enrolment of enrolled nurses and enrolled nurses (mothercraft), to grant recognition to:

    1) hospitals, nursing homes and educational and other institutions offering courses for the training of nurses, ***midwives*** and enrolled nurses and enrolled nurses (mothercraft), and
    2) the curricula for such courses, and
    3) diplomas, certificates, and other qualifications awarded to persons who successfully complete theses courses

i) to impose requirements or conditions for or relating to registration as a nurse ***or midwife*** , or enrolment as an enrolled nurse or enrolled nurse (mothercraft),

j) to grant to persons in prescribed circumstances or cases exemptions from a requirement or condition for or relating to registration as a nurse ***or midwife***, or enrolment as an enrolled nurse or enrolled nurse (mothercraft),

k) to cause the relevant particulars of qualified nurses ***and midwives*** to be entered in the Register, and the relevant particulars of qualified nurses to be entered in the Roll, in such a manner as the Board may direct,

**l) delete**

m) to determine in accordance with this Act applications for registration as a nurse, ***or midwife***, and for enrolment as an enrolled nurse or enrolled nurse (mothercraft),

n) to issue certificates of registration to registered nurses ***and midwives***, and certificates of enrolment to enrolled nurse and enrolled nurse (mothercraft),

o) to issue authorities to practice as a nurse ***or midwife*** as provided by section 33*, and

p) generally do any other act to exercise any other functions necessary for carrying the provisions of this Act into effect.

(2) The Board is empowered:

a) to terminate or vary, as it considers appropriate, any appointment made under subsection (1), and

b) to withdraw , or vary the conditions of, any recognition or exemption granted under that subsection, and

c) in accordance with this Act to cancel or suspend any registration as a ***nurse or midwife***, or enrolment as an enrolled nurse or enrolled nurse (mothercraft) or , where appropriate, to restore any such registration , or enrolment, and

d) in accordance with this Act, to cancel certificates of the kind referred to I subsection (1)(n).

<u>The objects clause</u> should include the following

" *promotion and maintenance of professional standards* ***of nursing and midwifery*** *practice in New South Wales to facilitate public confidence in the profession(****s)*** *and protect the community from unethical and incompetent practitioners"*

<u>Discussion points 4. and 5.</u>

The regulation of midwifery should conform to the title and practice model as outlined in 4.3.3.

Title regulation for midwives will involve the accreditation, by the Nurses (and Midwives) Registration Board of midwifery practitioners who may then adopt the professional title ***registered midwife***. The Nurses Act conveys no additional practice rights on registered midwives and any scope of practice in the areas of medication administration, prescribing and diagnostic test ordering is as a result of the known scope of practice of the midwife (ref NH&MRC etc)

<u>Discussion point 6.</u>

The regulation of midwifery should be by title alone. Section 7 as follows

**7 Unauthorised practice of midwifery**

(1) A person must not practise midwifery unless the person is a registered nurse who is authorised by the Board to practise midwifery.
Maximum penalty: 50 penalty units or imprisonment for 12 months, or both.

(2) Subsection (1) does not apply to or in respect of:
(a) any medical practitioner, or

* Where the term nurse appears, add ***or midwife***

(b) any person rendering assistance to a woman who is giving or has just given birth to a child where the assistance is rendered in an emergency, or

(c) any medical or nursing student, or any accredited nurse, acting under the supervision of a ***registered nurse who is authorised by the Board to practise midwifery,*** or

***REPLACE WITH THE WORDS "REGISTERED MIDWIFE"***

(d) any medical student (as defined in the *Medical Practice Act 1992*) acting under the supervision of a medical practitioner.

Discussion point 7.

Midwifery should be regulated by title alone within the Act, which would be renamed the Nurses and Midwifery Act. Midwives would not be required to be registered nurses and the amendment of the title of the act would reflect this change. Statutory professional self - regulation is the duty of the Nurses and Midwives Registration Board that will have a significant representation of midwives and will consult with other relevant organisations such as the NH&MRC in order to further clarify the scope of practice.

**PART B The safety of Midwifery**

The practice of midwifery and the practice of nursing are two separate and distinct practice domains which have been legally recognised in the UK, Netherlands, Canada, New Zealand, some states in the USA and parts of Scandinavia.

**The safety of Midwifery**

The safety of midwifery practice depends on the:

- ability of the midwife to practice within an autonomous framework;
- ability to facilitate functional collaborative relationships;
- ability of the midwife to be accountable to a professional statutory body recognised within legislation
- recognition of midwifery education separate to nursing.

**Research that supports the role of the Midwife**

During the past five years in New South Wales 95% of births took place in hospital (DOH 1998, AIHW 1998) where birth is 'managed' according to medical guidelines and protocols. This form of management determines and constructs what we know and understand about birth. The claim that all women are 'safer' giving birth in hospital under medical supervision in a clinical setting is strongly challenged by current midwifery research that clearly demonstrates the maternal morbidity associated with operative surgical intervention in childbirth, and the beneficial effect that midwifery models of care have on such outcomes.

Rates of operative intervention at birth, surgical pain relief and surgical birth are rising at an alarming rate (Young 1999, MacFarlane 1988). Medical interventions that have not been rigorously evaluated in terms of safety and cost are contributing to a rising cost in obstetric services. The increased spending has not significantly lowered the rates of maternal and infant morbidity over the past ten years (AIHW 1998); in fact it could be argued that it may in fact contribute to the rising rates of operative intervention in childbirth (Roberts et al in progress).

One of the most significant and measurable interventions that contributes to the safety of childbirth is 'continuity of care' (Page 1992, Flint 1989, Oakley 1990). This is widely defined as the supportive relationship that is established between the midwife and the woman and her family during pregnancy and childbirth. The midwife encourages the woman to be informed and become an active partner during her pregnancy and childbirth (Guilliland and Pairman 1995). Studies have shown that this form of midwifery relationship has a beneficial effect on women in childbirth by alleviating fear and perceived pain levels; lowering the need for pharmacological pain relieving drugs, lowering the rates of surgical operative intervention at birth; and increasing the mother's perception of a positive experience of childbirth. Midwifery care in childbirth has been shown to differ in management in effecting lower episiotomy and caesarean section rates with comparable outcomes to obstetric tertiary level care (Flint 1989, Rowley 1995, Turnbull 1996,Harvey 1996, McCourt et al 1996, Waldenstrom 1998, Hueston et al 1993, Kenny et al 1994, Guilliland 1998). Continuity of midwifery care is associated with lower intervention rates, with no statistically significant differences observed in maternal and fetal outcomes (Waldenström and Turnbull 1998).

Table 1 shows the results of published research that supports the claim that midwifery practice confers true benefit in terms of safety and lowered intervention rates in childbirth.

**Table 1.** Intervention rates in Childbirth: Outcomes affecting the mother in studies of Midwifery Care (Continuity of Care) compared to routine obstetric care: classified as significantly (s) lower, higher or the same[4].

| OUTCOME | FLINT | ROWLEY | TURNBULL | HARVEY | McCOURT | KENNY |
|---|---|---|---|---|---|---|
| Antenatal admission | lower | lower | | | | |
| induction | lower | lower | (s) lower | lower | lower | lower |
| ARM | lower | | | (s) lower | the same | lower |
| augmentation | (s) lower | higher | higher | lower | the same | higher |
| 1st Stage >6 hrs | higher | the same | the same | | the same | the same |
| epidural | (s) lower | the same | lower | lower | (s) lower | lower |
| analgesia | (s) lower | (s) lower | lower | (s) lower | (s) lower | higher |
| operative vaginal delivery | lower | lower | lower | lower | lower | (s) lower |
| caesarean | higher | lower | higher | (s) lower | the same | (s) higher |
| episiotomy | (s) lower | lower | lower | (s) lower | (s) lower | the same |
| vaginal tears | (s) higher | higher | lower | | higher | |
| intact perineum | the same | | higher | | higher | |

[4] Note: this is not a meta analysis rather a comparison of findings from published research

| | | | |
|---|---|---|---|
| antenatal ultrasound | | (s) lower | |
| continuous FHR | (s) lower | | lower |
| intermittent FHR | (s) higher | | higher |

*Source:: MA thesis, Wolfson Health Institute, UK, Sally Tracy 1996; updated 1999 **

It must be noted that the studies listed were undertaken in several countries, Australia, UK, Scotland and Canada, and the studies from the UK included some midwives who were not nurses and were educated within the 'direct entry' three-year undergraduate degree in midwifery program.

Current research being undertaken by the author based on routine data collected in the Midwives Data Collection database (MDC 1998) in New South Wales, has shown that women who are attended by private obstetricians have a much greater risk of maternal morbidity than those women who give birth in the public system. The study was undertaken to look more closely at the birth outcomes in a very 'low risk' population of primiparous women that comprises approximately 26% of the 171,157 women who gave birth to a live baby in New South Wales in 1996 - 97. Women were classified according to whether they had private health insurance or not. We considered women to be low risk using a similar but not identical definition adopted by the Clinical Standards Advisory Group (CSAG, 1992) to describe care of 'normal labour and delivery'. The subgroup of women were between 20 – 34 years of age, had no medical or obstetric complications, a single baby with cephalic presentation at birth within the 10th – 90th birthweight percentile; born at term (37 – 41 completed weeks gestation). Whilst it is not possible to infer causality from this particular research data, it should be noted that women who give birth in private hospitals are the least likely to have a midwife practicing continuity of care, and almost certainly will be attended by an obstetrician rather than a midwife. Privately insured women were considered to be healthier and better nourished than women with no insurance. And yet only 17% of privately insured women who were considered to be at the least risk of problems in childbirth had a spontaneous vaginal delivery. These women had twice the rate of epidural anaesthesia for childbirth and were nearly twice as likely to have an emergency caesarean section. They were three times more likely to have an instrumental delivery, and twice as likely to have an episiotomy
The research also showed a 'cascade' effect of operative intervention following an epidural. This manifested in a steep rise in instrumental and operative delivery by 200% for privately insured women and by 300% for women with no insurance ; and a significant fall in the rate of vaginal birth.[5]

The implications of this research evidence are very important for the practice of midwifery. These rates of "pathological" birth events are alarmingly high compared to models of care where midwives practice autonomously in the care of women in childbirth (Guilliland 1998,

[5] The published results of this research can be found at: Roberts CL, Tracy S, Peat B. Rates for obstetric intervention among private and public patients in Australia: population based descriptive study [see editorial]. *BMJ* 2000; 321(7254): 137-41 http://bmj.com/cgi/content/abstract/321/7254/137.

Tew 1991, Weigers 1997, Olsen 1998). The 'fallout' from birth outcomes such as this are really worrying when they are considered in the context of the health of children and mothers in terms of lowered breast feeding rates (Rajan 1994, Matthew 1989), rising levels of postnatal unhappiness, rising repeat ceasarean section rates, long term perineal morbidity and long term emotional problems (Fisher 1995, Hillan 1995, Creedy 1999).
A recent meta-analysis by Olsen (1997) showed that the total number of complications, the frequency of fetal distress, the frequency of neonatal respiratory problems and the frequency of birth trauma were significantly and consistently lower in births attended by midwives. Other clinical research has been undertaken in this area and it demonstrates that women who are cared for by midwives have far less operative intervention than those who aren't (Hueston et al 1993, MacDorman et al 1998, WEigers et al 1997). Similarly women who have continuous support in childbirth are less likely to need pain relief, operative vaginal delivery and augmentation (Hodnett 1999). Research indicates that an improvement in these outcomes has a 'snowball' effect in creating a beneficial effect on rates of breastfeeding (DiMatteo et al 1996) post natal unhappiness (Astbury 1994), and psychosocial trauma (Creedy 1999, Reynolds 1997, Ryding 1998).

**Recommendations**

- Continuity of care can only be practiced in a sustainable manner when midwives have a statutory regulation governing their right to practice with autonomy. This means that the midwife is not accountable to a medical practitioner; she is not restricted by the regulations governing nursing; she is accountable to the woman in her care and attends the woman during the ante/intra and post natal period.
- Statutory autonomy for midwives will provide women with an alternative to the maternity care being offered to them at present. The WHO, the International Federation of Gynecology and Obstetrics and the International Confederation of Midwives have all identified the midwife as the 'most appropriate and cost-effective type of health provider to be assigned to the care of normal pregnancy and normal birth, including risk assessment and the recognition of complications' (WHO 1996).
- Australia must reconsider the appropriateness of midwifery as only an add-on certificate to general nurse training. Midwives are trained in 'direct entry' undergraduate midwifery programs in the Netherlands, the UK, Canada, New Zealand and some programs in the USA. It is possible to design a less ethnocentric model of training than is presently available. In doing this it would address the serious lack of indigenous midwives available to work with indigenous women, who for the most part are not cared for within a culturally safe model in Australia.
- The revision of the Nurses Act 1991 to become a Nurses and Midwives Act will restore autonomy to midwives, increase choices available to women and their families and aim to increase the provision of continuity

of care. Women have been socialised to believe that birth is an illness and the challenge of the legislation change is to change that perception.

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