CHAPTER 4

CARE DURING BIRTH

The birth setting

4.1 Almost all Australian babies are born in hospital. Most are born in traditional labour wards, now generally known by the more politically correct term 'delivery suites'. A small percentage of hospital births take place in alternative birthing centres the majority of which are located either within hospitals or very close to them.[1] The Australian Institute of Health and Welfare estimated that in 1996 birth centres accounted for 2.5% of all births, but the figures do not include Victoria and Tasmania, where confinements in birth centres are not separately enumerated.[2]

4.2 A very small number of Australian babies is born at home. The figure was 0.3% in 1996, although the Australian Institute of Health and Welfare cautions that home births 'are underascertained in some State and Territory perinatal collections'.[3]

4.3 This pattern does not vary significantly between States. Nor is it greatly influenced by the ethnic background or health insurance status of the mother.

4.4 Irrespective of birth setting, mortality outcomes are exceptionally good for Australian mothers and babies by world standards (although this is not the case for Aboriginal mothers and babies for whom mortality rates are double those of the non indigenous population, as noted in chapter 2). Appendices 3 and 4 give international comparisons.

4.5 In the period 1991-93 there were 3.5 maternal deaths per 100,000 confinements directly related to childbirth.[4] However, the underlying rate is higher than this. In 1994 the rate was 7.0 deaths per 100,000 births. Averaged over the period 1990-1994 it was 5.3.[5] The safety of childbirth in Australia is reflected in Australian Bureau of Statistics figures on deaths from complications in pregnancy, childbirth and

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1 The Committee notes the reservations expressed by the NHMRC on the use of this term (ie that it may encourage the view that maternity services are a set of alternative systems run by competing professional groups rather than an integrated set of options.) However, it considers the term is in such general use and so widely understood as to justify its use in this Report.

2 Australian Institute of Health and Welfare. *Australia's mothers and babies 1996*, p.5.

3 Ibid, p.5.

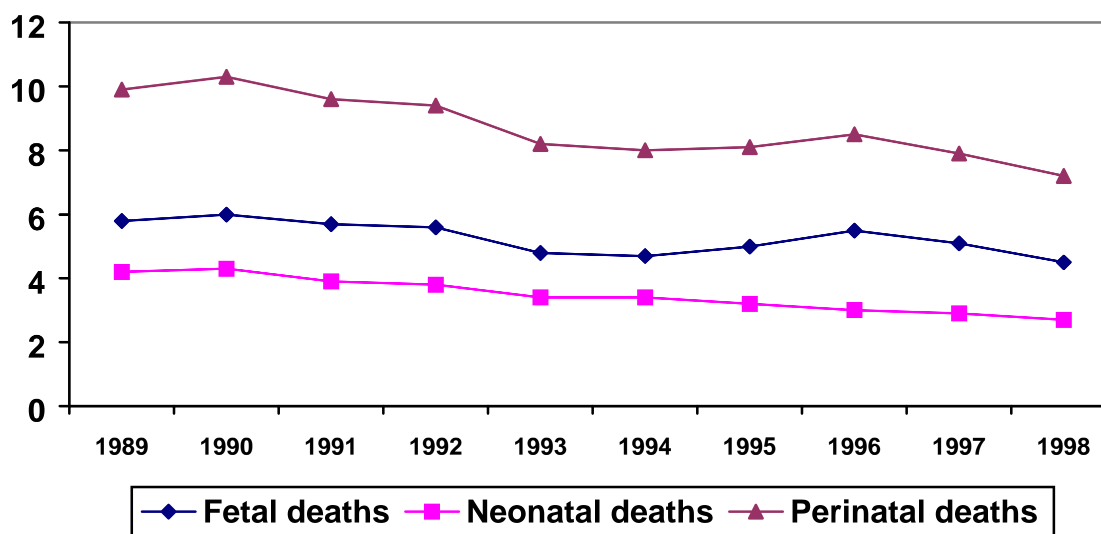
4 Submission No. 97, p.5 (Department of Health and Aged Care).

5 de Looper M. Kuldeep B. *International health – how Australia compares,* Australian Institute of Health and Welfare, Canberra, 1999, p.25.

the puerperium: 13 in 1989 and 1991, 15 in 1993, 24 in 1995, 11 in 1997 and 7 in 1998.[6]

4.6 Foetal, neonatal and perinatal death rates were 5.5, 3.0, and 8.5 per 1000 births in 1996. By 1998 the foetal death rate had dropped to 4.5, the neonatal rate to 2.7 and the perinatal rate to 7.2 per 1000 births.[7]

Foetal, Neonatal and Perinatal Deaths



Rates are per 1,000 total relevant births.

Source: ABS, *Causes of Death Australia,* Cat No 3303.0, Table 3.1 p.60.

4.7 Australian women value safety for their babies and themselves above everything when making choices about birth settings. For this reason the vast majority choose to birth in hospitals where perinatal and maternal mortality rates are very low.

4.8 But while women may be happy with the outcomes achieved, in terms of perinatal and maternal mortality, they are generally not impressed by the measures adopted to achieve them. The evidence suggests that they resent the way in which childbirth has been taken over by the medical profession rather than treated as a natural process, with a concomitant increase in the level of interventions and consequent morbidity outcomes (described in the following chapters) and in the disempowerment of the women giving birth. While acknowledging that the medical approach may be necessary in a small number of cases they consider it inappropriate

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6 Australian Bureau of Statistics, 1999 *Causes of Death, Australia.*

7 Australian Institute of Health and Welfare. A*ustralia's mothers and babies 1996*, p.xiv and Australian Bureau of Statistics 1999. *Causes of Death, Australia*. Perinatal deaths are stillbirths plus neonatal deaths. Neonatal deaths are those of babies within 28 days of birth. Foetal, neonatal and perinatal deaths are normally given per 1,000 births. Maternal deaths are given per 100,000 births because total numbers are so small.

for most women compelled or persuaded to submit to it without any medical justification. They are further alienated by a system which too often fails to provide continuity of carer so that they may be tended during birth by total strangers.

4.9 Hospitals have been slow to respond to community pressure for a more holistc approach to birth, as have governments and some elements of the medical profession. Some initiatives have been adopted as noted. The Alternative Birthing Services Program has been an important catalyst in this respect. But much remains to be done. Possible future directions will be considered in connection with discussion of the development of best practice guidelines for care during birth.

Birth in a hospital delivery suite

4.10 Although most maternity hospitals (and maternity units within general hospitals) are relatively small (half had fewer than 100 births in 1996), many births occur in large units. In 1996 more than 42% of all births were in hospitals conducting more than 2,000 confinements annually.[8] Arrangements are normally made during pregnancy for women deemed at risk of complications during birth to be admitted to large hospitals where obstetrical specialists and a range of services are available. This policy has been a major contributor to Australia's current very low rates of maternal, and more especially perinatal, morbidity and mortality.

4.11 Just over 30% of mothers giving birth are privately insured. The figure ranges from 30.2% in Western Australia to 35.5% in the Australian Capital Territory.[9] (Figures were not recorded in Victoria and the Northern Territory at this time and were not available for Tasmania.)

4.12 During birth in a hospital delivery suite, a woman may be in the care of midwives, of a general practitioner, of a registrar, of a specialist obstetrician or of any combination of these. Usually she is cared for by midwives during labour, with an obstetrician or registrar on call who then attends at the birth, at least in the case of privately insured women. General practitioners rarely have the right to attend hospital births in urban centres. A woman is more likely to be attended by a specialist obstetrician during labour and birth if she is privately insured or if she or her baby are deemed at risk of developing complications.

4.13 Even healthy women who give birth in traditional hospital labour wards and have uncomplicated labours run a high risk of some form of intervention (as discussed in the following two chapters). They may or may not be familiar with the midwives attending them in labour, depending upon the extent to which shared care arrangements are in place which extend through pregnancy into birth and beyond into the post natal period. (Shared care arrangements are discussed in chapter 2.)

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8 Ibid, p.6.

9 Ibid, p.13.

4.14 Women who enjoy continuity of carer right through pregnancy and birth express greater satisfaction with their care than do women assisted by a range of professionals. A study by Brown and Lumley suggested that while consumer satisfaction was highest among privately insured women attended by a specialist during their antenatal care, women in this group were no more or less likely to be happy with their care during birth than women receiving standard public hospital or general practitioner care.[10] This is because in the former situation it is rare for an obstetrician to be present throughout labour. So women must rely on midwives or registrars with whom they are unfamiliar, and who are not familiar with their histories and particular concerns.

4.15 Dissatisfaction with the medical emphasis of hospital births and with discontinuity of care were major factors driving consumer demand for alternative, more woman centred approaches to birth, with midwives as the primary care givers. Some traditional hospitals have responded to this demand by establishing team midwifery programs for healthy women. Westmead hospital is one.

> 7% of women giving birth [at Westmead] in 1998 enrolled in this programme. Though an obstetrician is ultimately responsible for these patients, they are seen in a separate clinic and cared for by a team midwife in labour ward. Team midwives only rarely need to care for more than one woman at a time in labour ward because the numbers of women booked for this model of care are limited to a number which makes this feasible. Women receiving team midwifery care have a greater degree of continuity of care than other public obstetric patients.[11]
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> 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. This model of care has now become part of the routine options of care available for women who choose to birth at this hospital.[12]

4.16 The Committee received many submissions supporting the work of team midwives at John Hunter, whose system has been adopted by many other hospitals.

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10 Brown Stephanie, Lumley Janet. *Changing childbirth: lessons from an Australian survey of 1330 women,* British Journal of Obstetrics and Gynaecology, February 1998, vol. 105, p.152.

11 Submission No. 34, p.1 (Westmead Hospital, NSW).

12 Submission No. 38, p.10 (NSW Midwives Association).

The Committee was therefore dismayed to learn that the program is now under threat, with its funding to be diverted to other hospital programs.[13]

4.17 The team midwifery approach is only one of a range adopted by hospitals in response to consumer demand for a less interventionist medical approach to childbirth for healthy women. Others include the midwifery case load model and variations on the shared care model. Aspects of the midwifery case load model were explained by a Victorian witness.

> There are different midwifery models that provide total continuity of care. An example is a caseload model. The midwives actually take a caseload of about four women throughout their pregnancies and provide the antenatal, intrapartum and postnatal care.[14]

Birth in an 'alternative' birthing centre

4.18 Although originally established as alternatives to standard hospital models of birth care, birthing centres are now accepted as mainstream services. They are therefore generally referred to in the following discussion simply as 'birth centres'.

4.19 A birth centre may be housed in a self contained area within a maternity hospital. It may be a free standing building in hospital grounds or adjacent to a hospital or, more rarely, it may be located totally independently of a hospital.

4.20 Birth centres are a deliberate attempt to move away from the medical model of care provided in labour wards, and to replicate the atmosphere prevailing at home, while ensuring immediate access to medical attention and services should they be required. Ideally, they are designed to provide a home like atmosphere with rooms furnished like bedrooms rather than hospital wards, for example with a double bed rather than the usual hospital variety. They have ready access to shower and bath facilities and some are completely self contained units. This is the position at the Queen Elizabeth Hospital in Adelaide, for example, and at the King Edward Memorial Hospital for Women in Perth. Many regular labour wards are moving in the same direction.

4.21 Where hospitals or health services have had no real commitment to them, the centres may in fact be no more than a room at the end of a labour ward with no special facilities and no attempt to introduce a non medical approach to birth.

> The concept of birth centres has become murky in Australia as many traditional labour wards have been decorated with curtains and bedspreads

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13 See for example Submission No. 165, p.5 (Team Midwives, John Hunter Hospital) and Submission No.180, p.1 (Ms Katrina Maranik, NSW).

14 *Committee Hansard,* 6.9.99, p.103 (Australian College of Midwives Inc, Vic Branch).

> and renamed birth centres without any fundamental change to the medical protocols that still control woman and midwives. [15]

4.22 Birth centres are staffed and run by midwives. Although obstetricians and registrars (or general practitioners in some centres) may be on call they do not assist at labour or birth unless requested by the midwives to do so. In some birth centres (and some labour wards) where a team approach has been adopted midwives and general practitioner-obstetricians both may be present during labour and birth.

4.23 Access to birth centres is limited to women deemed at low risk. In most birth centres strict admittance protocols apply. Women who are accepted by birth centres early in their pregnancy will be transferred to regular hospital labour wards if they develop complications during pregnancy. Similarly, low risk women who develop complications during labour are immediately transferred to 'mainstream' hospital labour wards. Transfer rates are quite high. At the birth centre at the King Edward Memorial Hospital for Women in Perth, for example, in the year to January 1997 approximately 29% of women were transferred prior to the onset of labour and a further 17% were transferred during labour.[16] 'Nearly 30% of women who planned a birth centre birth in NSW in 1997 were transferred to the labour ward for the delivery'.[17]

4.24 Although protocols govern both admittance to birth centres and transfer out of them in the event of complications, there is great variety in their content. In Melbourne, for example, a woman who has had a previous Caesarean section is not permitted to book into a birth centre. In Sydney she may be accepted.[18] In South Australia the position varies from hospital to hospital.

> We have produced guidelines for South Australia of the people who should be in a birthing centre, or should be informed about birthing centres, and who could go to a birthing centre. Individual hospitals interpret those guidelines differently. For example, the Queen Elizabeth Hospital allows women who have had a previous caesarean section to go to their birthing centre, whereas this hospital [the Women's and Children's in Adelaide] does not.[19]

4.25 More research, especially research using randomised trials, is needed on which to base best practice guidelines governing the content of these protocols.

4.26 The earliest birth centres were established in the 1980s, in response to consumer demand. They were funded by State health departments. Later the

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15 Submission No. 15, p.13 (Dr Kathleen Fahy and Dr Karen Lane, University of Queensland).

16 See Submission No. 62, p.9 (Australian College of Midwives, WA).

17 Submission No. 153, p.10 (Maternity Alliance, NSW).

18 See Submission No. 14, p.12 (Australian College of Midwives Inc, Vic).

19 *Committee Hansard,* 7.9.99, p.206 (Perinatal Society of Australia and New Zealand).

Commonwealth, reacting to the same pressures, funded the Alternative Birthing Services Program (ABSP). It began in 1989 and provided funds for the establishment of birth centres in the public health system and for the payment of midwives attending at home births or in birth centres. It has also funded a range of innovative outreach and antenatal services. Commonwealth funding for the program in the period 1989-90 to 1996-97 was $15.4 million. Since 1997-98 ABSP funding has been broadbanded with general public health funding provided to the States under the Public Health Outcome Funding Agreements.

4.27 Birth centres account for only a small proportion of total births. In 1996 there were 4,652 such births (2.5% of all births), an increase from the 2,405 recorded in 1992. These figures exclude Victoria and Tasmania where birth centre births were not separately recorded.[20]

4.28 The objective of the ABSP was to promote greater choice for women giving birth. It aimed to promote a philosophy of care which emphasised the role of the midwife as a primary carer and pregnancy and birth as normal life events for most women. It was also intended to encourage State health services to trial a range of models of care.

4.29 The ABSP had a strong emphasis on the provision of alternative services for Aboriginal and Torres Strait Islander women. During its first phase, 25% of its funds were targetted to this group. The focus has been on antenatal and post natal care rather than birth, although Aboriginal programs include, for example, a community based birthing service for Koori women in metropolitan Victoria, run by the Victorian Aboriginal Health Services Cooperative and a similar project in Adelaide run by the Northern Metropolitan Area Health Service. Both of these services provide continuity of care for Aboriginal women through the antenatal period, the birth and into the post natal period.

4.30 The birth centres have been an outstanding success. Their maternal and perinatal morbidity and mortality rates are comparable to, or better than, those of hospital labour wards. Even though their client group is restricted to women in the low risk category, while that of major centres includes most women considered at high risk, their results are impressive, both in terms of medical outcome and in terms of consumer satisfaction.

4.31 The cost of births at birth centres is comparable to, or slightly higher than, the cost of uncomplicated vaginal deliveries at public hospitals, at least in those centres for which figures were supplied to the Committee. Queensland Health, for example, advised that the cost of an uncomplicated vaginal delivery of a public patient at Mackay Hospital was $1,473 in 1999. The cost at Mackay Birth Centre was $1,840.[21]

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20 Figures are from Australian Institute of Health and Welfare. *Australia's mothers and babies 1996*, p.5.

21 Additional information, 30.10.99 (Queensland Health).

4.32 Birth centres have lower intervention rates than labour wards and much higher levels of consumer satisfaction. Women particularly report greater feelings of empowerment in birth centres. Women in the centres are given greater flexibility than the hospitals generally permit in the manner in which they give birth, and report that they have more input to decisions taken during labour and birth.

4.33 Support for birth centres is widespread. Demand exceeds supply in most centres.

> The birthing centres are overfull in Adelaide and cannot provide enough places for the women who want them.[22]

4.34 In the centre at the Royal Women's Hospital in Brisbane potential clients are selected by ballot every month, with applications approximately double the centre's capacity to respond.

4.35 Facilities have not been expanded to keep pace with this demand. In fact, some very well supported centres have recently closed, or are threatened with closure.

> The average number of babies born every year in Western Australia is 25,000. The state has only two Birth Centres in the Metropolitan Area, a total of only five (5) beds…The only rural Birth Centre in Mandurah was closed when the public hospital was privatised. This means that there are no Birthing Centres outside the Metropolitan Area.[23]
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> As I understand it, the birth centre at Swan District was an Alternative Birthing Services project and it was funded for the length of time covered by the Alternative Birthing Services Program. I think the funding is just about over.[24]

4.36 The Health Department of Western Australia disputed this, claiming that 'since 1994/95, Western Australia has received over $230,000 annually from the ABSP, with broadbanding under the Public Health Agreement having no effect on the ABSP allocation'.[25]

4.37 This is in part a funding issue. The position was succinctly stated in a Northern Territory evaluation of the ABSP.

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22 *Committee Hansard,* 7.9.99, p.226 (Birth Matters, SA).

23 Submission No. 62, p.8 (Australian College of Midwives, WA).

24 *Committee Hansard,* 8.9.99, p.364 (Australian College of Midwives).

25 Additional information 21.10.99 (Health Department of Western Australia).

> The ability of the Alternative Birthing Services Program to promote birthing as a normal life event is hindered by the lack of funds available compared to those available to parties with an interest in keeping it medicalised.[26]

4.38 The Commonwealth Alternative Birthing Services Program was a pilot program. The intention was that projects established by the program which proved successful in terms of safe outcomes and consumer support would continue with State funding. While this intention is certainly being fulfilled in some area health services the practice is by no means uniform.

4.39 Funding considerations are not the only barrier. Some midwives and consumer groups pointed to opposition from obstetricians to establishment, retention or expansion of birth centres.

> **In 1995** consulting obstetricians at KEMH prevented the establishment of a Commonwealth Alternative Birthing Services Programme under the auspices of the hospital, by threatening to withdraw their clinical services from all women, after hours and on weekends.[27]

4.40 The success of birth centres extends beyond the centres themselves. They have had an impact on attitudes and practice in traditional labour wards.

> …the birth centre culture has filtered out through the rest of the practice of midwifery…I see the sorts of philosophies that the birth centre brought in going through what one used to call labour wards – we call them delivery suites these days.[28]

4.41 Their impact on the general community can be expected to increase among groups not so far touched by their development, according to some evidence to the Committee.

> I think the multicultural society which we have may well increase our numbers in the family birth centre. I think it is just the beginning of perhaps a much larger input into and interest in the family birth centre type of situation when the multicultural and perhaps the less educated or informed people are becoming more and more informed of that option.
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> …I think that up to now the birth centre philosophy and birth centre facility have not been exploited as much as they should have been with some of the ethnic groups which we now have. There is a lot of potential for that to become a very much more used option.[29]

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26 Territory Health Services, Women's Health Unit. *Evaluation of the Alternative Birthing Services Program in the Northern Territory,* 1997, p.iv.

27 Submission No. 62, p.12 (Australian College of Midwives, WA).

28 *Committee Hansard,* 6.9.99, p.145 (Royal Women's Hospital, Vic).

29 Ibid, p.145.

4.42 Many recent reports[30] have favoured the further development of birth centres provided they continue to attract consumer support and continue to provide services that are equally safe to those provided by hospital labour wards. The NHMRC did not support the expansion of birth centres remote from hospitals, on safety grounds.

4.43 The Committee favours the continuation and expansion of birth centres. As noted, they have received support in many recent reports. Support was also expressed consistently in evidence provided to the Committee by consumer and midwife groups. The Committee considers that birth centres have demonstrated that they have community support, are safe and are cost effective. They are now a widely accepted mainstream component of birthing services in Australia rather than a fringe alternative. It is therefore appropriate that they be maintained and extended by hospitals, through hospital budgets, rather than through the Alternative Birthing Services Program, which is now part of Public Health Outcome funding.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure the continuation and expansion of hospital birthing centres.

Home birth

4.44 Home birth represents a very small proportion of total births in Australia. As noted, they accounted for only 0.3% of total births in 1996.[31] The number has been fairly consistent over recent years, although supporters claim that more women would birth at home if current financial and other constraints were removed.

4.45 The Australian Institute of Health and Welfare suggested that women who favoured the non medical approach of home birth were turning increasingly to birth centres and that this accounted for the fact that there had been no increase in home births despite increased consumer concerns over the medicalisation of pregnancy and childbirth.

> Women who sought to avoid what they would regard as unnecessary intervention and may have chosen home birth for that reason and for the type of care that they get are increasingly using birthing services linked to hospitals for their care. So we are not seeing an increase in home births in Australia.[32]

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30 These include: NHMRC. *Options for effective care in childbirth*, 1996. Health Department of Victoria. *Having a Baby in Victoria,* 1990. West Australian Legislative Assembly. *Report of Select Committee on Intervention in Childbirth,* 1995. NSW Health Department. *Final Report of Ministerial Taskforce on Obstetrical Services in New South Wales,* 1989.

31 Throughout this Report the term home birth is used only to indicate **planned** home births, whether they are completed there or in a hospital setting.

32 *Committee Hansard,* 27.8.99, p.26 (Australian Institute of Health and Welfare).

4.46 A major inhibitor to growth in the number of home births is concern about rapid access to medical expertise and facilities in the event of unforeseen complications. Although most home birth midwives accept only healthy women at low risk of developing complications, such risks can never be totally predicted. This is borne out by the fact that a significant number of women who begin their labour at home are eventually delivered in hospital. The figure was said to be 12.9% in 1988-90.[33]

4.47 The medical risks of home birth are cited by the medical profession as the reason for their opposition to it.

> With infant and maternal mortality the lowest it has ever been, people have begun to believe that childbirth is totally without risk, and that all the medical intervention is both invasive and unnecessary. They advocate a return to home-delivery, without medical management, and often without any medical support. The end result of this can be deduced by comparison with the situation in the Third World, where no woman has the chance of a hospital delivery, and where 9 women in every 1000 die during or after labour.
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> …Home delivery survives only as an atavism. It can only be justified in terms of personal gratification, and it has nothing to do with best practice, or indeed any form of professional standard.[34]

4.48 The Royal Australian College of Obstetricians and Gynaecologists is opposed to home birth on safety grounds but, in recognition of the fact that it does occur, has developed best practice guidelines to assist women contemplating this option.

> The College recognises that a small number of women will chose domiciliary confinement. While considering that homebirth exposes the mother and child to unacceptable risks, the College has recommendations to guide persons seeking home delivery.[35]

4.49 Another factor restricting the appeal of home birth is its cost. This ranges from $1,500 to $2,500 according to evidence provided to the Committee. These costs are not met by Medicare and must therefore be borne by the woman and her family. For this reason home birth is not an option for many women who might otherwise choose it. Few private health funds cover the costs of home birth either.

> Failure to make midwifery fees claimable through Medicare discriminates against the midwife and the women who wish to choose this model of care. With the WHO recommending the midwife as the most appropriate carer for normal healthy women in pregnancy and birth, it is ironic that their fees are

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33 See Submission No. 15, p.9 (Dr Kathleen Fahy and Dr Karen Lane, University of Queensland).

34 Submission No.18, pp.2-3 (Dr Ron Chang and other medical specialists, Qld).

35 Submission No. 17, p.7 (Royal Australian College of Obstetricians and Gynaecologists).

> the only ones *not* claimable either through Medicare or most private health insurance funds.[36]

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> Midwifery care for homebirths should attract an equitable medicare rebate. Many women from lower socio-economic areas are extremely disadvantaged and discriminated by the lack of a medicare rebate for the services of independent midwives. A more general application would see homebirth made free to **all** women through medicare taking up its public responsibility in rebating the care provided by midwives.[37]

4.50 Women birthing at home therefore tend to be of higher socio economic status than those who give birth in hospital.

> A SA study in 1990 found women who had planned homebirths were older and of a higher socioeconomic group than women who gave birth in hospital.[38]

4.51 Because of the small number of women birthing at home, there is not enough work available to the independent midwives who assist them. Such midwives have therefore to seek work in hospitals or community based centres (where these institutions will accept them - often will not). Here they have less responsibility and autonomy and may lose some of their skills. Many of them are uncomfortable with the medical approach adopted in hospitals where, they consider, their skills are undervalued.

4.52 Midwives are leaving the profession and recruitment of new midwives is insufficient to replace them. High attrition rates place great pressure on those remaining. There are parallels here with the situation facing specialist obstetricians.

> The general public is being swayed to think that the hospital is more safe because of the technology, but many authors assert that the use of technology is actually deskilling the midwives in this “technobirthing” environment. The midwives are no longer ‘with’ women but are minders of machines and reporters to doctors.[39]

4.53 The threat of litigation is also a factor adversely impacting on the recruitment and retention of independent midwives.

> …medical insurance is having quite an impact on the way - at least in the private sector - the options are available to women. Because there is still an

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36 Submission No. 20, p.7 (Ms Robin Payne, Choices for Childbirth, Vic).

37 Submission No. 30, p.4 (Homebirth Network of South Australia).

38 Mardi Chapman. *Homebirth Control.* Australian Doctor, 29 January 1999, p.34. The findings of the study referred to were published in the Medical Journal of Australia 1990, 153: pp.664-71.

39 Submission No. 81, p.4 (Launceston Birth Centre Inc).

> attitude by organisations such as the Medical Defence Union that doctors and midwives should not be working together. Doctors should not be providing backup for visiting midwives. This causes a problem, because it is difficult for midwives to get the required amount of insurance in order to have access to visiting rights in hospital.[40]

4.54 Home birth may be viewed as one manifestation of the widespread reaction by women against the medicalisation of pregnancy and birth. They resent the way in which hospitals treat healthy women in labour as if they were sick and require medical intervention.

4.55 The Committee heard from many advocates of home birth. Most had themselves given birth at home and were keen to extend the benefits which they had received to other women. The following excerpts are typical of many received by the Committee.

> The degree of medical intervention practised in hospitals is unnecessary and frightening and this led me to a search for different approaches for the birth of my daughters…I wish to share these experiences with the Committee to highlight the importance of informed choice, continuity of care and respecting the normality of pregnancy and childbirth.[41]

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> From our experience, we know that birthing at home is good for women, babies, families, communities and cultures and it is also cost effective when compared to the expense of giving birth in hospital.[42]

4.56 Most advocates of home birth recognised that it was not an option for women at risk of developing complications during labour or delivery.

> I wish to point out that I do not believe that giving birth at home is somehow inherently 'better' than giving birth in hospital. I am well aware of the fact that some women and babies require the type of medical care only possible in a hospital setting, and I do not underestimate the importance of such care. I am also aware of the fact that many women feel safer and more comfortable labouring and giving birth at hospital than they would at home. However, there are a number of women with low-risk pregnancies who, if given the choice, would prefer to give birth at home and who could do so safely if the type of care provided under the CIS [Childbirth Information Service] model was more widely available.[43]

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40 *Committee Hansard*, 15.9.99, p.561 (Association for Improvement in the Maternity Services, Qld).

41 Submission No. 123, p.2 (Ms Lisa Joseph, NSW).

42 Submission No. 171, p.6 (Birthplace Support Group Inc, WA).

43 Submission No. 36, p.6 (Ms Clarissa Cook, Tas).

4.57 Home birth supporters considered that the risks of home birth were exaggerated by the medical profession, which saw it as a threat to their authority.

> When I decided on birth at home, most medical practitioners I spoke with abhorred my decision, branding it as unsafe and foolish. I felt that I had made the right decision and set about informing myself about the practice of home birth. What I discovered was that claims about the dangers of home birth are based on opinion, not facts. These claims are also perpetuated by those with the least motivation for encouraging women to access this model of care. Their motivation is less about safety and more about politics, power and money.
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> …I believe the silence on these issues [safety of home birth] is testimony to the power of the medical profession generally in sustaining the medical model of birth and suppressing the development of superior woman-centred midwifery care.[44]

4.58 Independent research on the safety of home birth in Australia is not conclusive. Where the numbers are so small it is difficult to draw definitive conclusions. Some overseas studies have shown that home births are not inherently less safe than hospital births.

> It is concluded that no empirical evidence exists to support the view that it is less safe for most low-risk women to plan a home birth, provided that the pregnant woman is motivated and, furthermore, selected and assisted by an experienced home birth practitioner, and provided that the home birth practitioner, in turn, is backed up by a modern hospital system should a transfer be needed. It is further concluded that home birth as managed in the included studies may well have other advantages compared with standard hospital care.[45]

4.59 Other studies dispute this. A study by Hilda Bastian and others which compared data on 7,002 planned home births in Australia during 1985-90 with national data on perinatal deaths and outcomes of home births concluded that Australian home births carried a high death rate compared with both all Australian births and home births elsewhere. The largest contributors to the excess mortality were underestimation of the risks associated with post–term birth, twin pregnancy and breech presentation, and a lack of response to foetal distress.[46]

4.60 In view of these findings the authors stated that:

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44 Submission No. 20, pp.7-8 and 11 (Ms Robin Payne, Choices for Childbirth, Vic).

45 Olsen Ole. *Meta-analysis of the Safety of Home Birth.* Birth, 24: 1 March 1997, p.11. This study examined the birth outcomes for 24,092 primarily low risk women in six controlled, observational studies.

46 Bastian H. Keirse J. N. C. Lancaster P. A. L. *Perinatal deaths associated with planned home birth in Australia: population based study.* British Medical Journal, vol. 317, 8 August 1998, pp. 384-387.

> While home birth for low risk women can compare favourably with hospital birth, high risk home birth is inadvisable and experimental.[47]

4.61 Certainly, women birthing at home undergo fewer invasive procedures so the morbidity rates associated with these procedures are lower.

> Women birthing at home between 1988-90 experienced mainly spontaneous birth (86%) and only 12.9% were transferred to hospital during labour or in the postnatal period…Of those women who birthed at home, 93% required only non-medical or social support by the midwife and support persons; 1.5% required Pethidine and further 5% used acupuncture or homeopathy and herbal remedies.[48]

4.62 Home birth pilot programs were developed by some States using Commonwealth funding provided through the Alternative Birthing Services Program (ABSP). This funding was used to pay the fees of independent midwives attending low risk births. It has been suggested that in States which did not take up these funds and where therefore, there were fewer constraints on the women accepted for home birth, there has been an increase in high risk births at home.

> States which did not use the opportunity of developing a home birth program based on low risk criteria (NSW, Victoria and Queensland) have seen an increasing trend of midwives taking on women with high risk pregnancies for delivery at home…The ABSP homebirth pilot programs have ensured safe home birth practices with good access to hospitals. It is regrettable that no States have taken up the challenge of on-going funding of home birth services.[49]

4.63 Home births are favoured by only a small number of women in Australia. In other countries the situation is quite different. In Holland, to which the Committee's attention was repeatedly directed, over a third of babies are born at home and perinatal and maternal morbidity and mortality rates are low. The reasons for the difference in approach are complex. Cultural and social factors are important.

4.64 Holland has a much more integrated health system than does Australia, and provides greater continuity of care through the antenatal period, birth and into the post natal period. Home birth is much more widely accepted there, by the population generally and by the medical profession. Midwives undergo a more rigorous training in Holland than they do in Australia. Finally, because Holland is a small and densely populated country, women giving birth at home are never far from hospital support should this become necessary.

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47 Ibid.

48 Submission No. 15, p.9 (Dr Kathleen Fahy and Dr Karen Lane, University of Qld) Figures quoted are from Bastian H. and Lancaster P. A. L. *Home Births in Australia 1998-1990.* AIHW National Perinatal Statistics Unit, Sydney, 1992.

49 Submission No. 153, p.11 (Maternity Alliance, NSW).

4.65 It seems likely that home birth will remain the preferred choice for a minority of Australian women. Its proponents suggest that their greatest impact will not be to increase the number of home births but rather to 'humanise' hospital births by influencing hospital staff to adopt a less interventionist, more holistic and woman centred approach to birth. Moves in this direction are already evident in some hospitals, although they have not gone nearly far enough in the view of many witnesses before the Committee.

> I have had discussions with a very prominent homebirth midwife – I do not see any reason not to name her – Maggie Lecky-Thompson. I enjoyed my discussion with her and she herself volunteered that the impact of the homebirth movement was not going to be to move birth to the home but to civilise hospital births. I think she is absolutely right. I think that in the last 10 to 15 years, since it has become very apparent to any obstetrician that obstetrics was being practised in a way which was not necessarily either beneficial to mothers or making them happy, obstetricians have been changing their practice.[50]

4.66 The Committee supports the continuation of this option for healthy women. It considers that the available evidence, both in Australia or overseas, is such as to justify its retention and notes that in Holland, for example, where a third of all births take place at home, morbidity and mortality rates are comparable to those in Australia.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government continue to fund midwives to assist at home births for women at low risk through the Public Health Outcome Funding Agreements.

Birth in rural and remote locations

4.67 Women living in rural and remote areas have fewer local options for care during birth than do those in urban centres. Basically they can either give birth at their local hospital, attended by a midwife and a general practitioner or, if there is no local hospital, transfer to a regional or other urban centre offering the range of services outlined earlier. Few women have access to the services of a specialist obstetrician. Home birth is problematic in rural areas because of the distance and time involved in transferring a woman to a major centre should complications develop during labour.

4.68 Women with health problems or considered at risk of complications during birth are normally encouraged to give birth at a metropolitan or regional centre where specialist staff and facilities are available if required. For women in remote communities this requires transfer to urban centres well before the anticipated date of birth. This practice, which is in place in all States and Territories, has been a major contributor to Australia's current very low rates of perinatal and maternal morbidity and mortality.

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50 *Committee Hansard*, 14.9.99, p.497 (Dr A.F.Pesce, Westmead Hospital).

…the regionalisation of perinatal care, whereby high risk mothers and babies are transferred from smaller units to tertiary care centres, has probably been the predominant factor in reducing perinatal death rates.[51]

4.69 Some evidence to the Committee suggested that despite women's reduced choices in rural areas, outcomes are not compromised.

Clearly, it is not possible to have a range of options for women in rural areas doing only 20 deliveries per year. On the other hand, the doctors and hospital midwives in those districts offer a level of continuity of care that city dwellers could only dream of.[52]

* * *

Although access to obstetric facilities for rural and remote women is often limited, health outcomes for women choosing to deliver in rural and remote locations are not necessarily worse than for metropolitan teaching hospitals.

In fact, the converse is true. Perinatal mortality and morbidity statistics from GP obstetric units in rural areas in NSW and rural Canada have been identified as being among the best in the world.[53]

4.70 Other evidence suggested that high skill levels could not be maintained by staff in hospitals carrying out only a small number of births each year. As noted, half of the maternity units in Australia have fewer than 100 births a year. Almost all of these are in country areas.

4.71 For healthy women giving birth with the assistance of a midwife and a general practitioner in a country hospital outcomes are comparable with those in metropolitan areas. It has been suggested that in part this is because country general practitioners are skilled at identifying possible problems in pregnancy and arranging for the transfer of women at risk to metropolitan services.

The reasons for this [comparable outcomes for rural general practitioner care] are complex but it is believed that experienced rural GP obstetricians are good at identifying potential problems promptly and transferring patients to a larger centre in a timely and appropriate fashion.[54]

4.72 There are generally lower intervention rates in country areas than in metropolitan centres for comparable populations. This may in part be because fewer options for intervention are available. Anaesthetists are in short supply, for example,

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51 *Committee Hansard,* 27.8.99, p.25 (Australian Institute of Health and Welfare).

52 Submission No. 5, p.2 (Dr B.R. Pridmore, Queen Elizabeth Hospital, Adelaide).

53 Submission No. 70, p.4 (Royal Australian College of General Practitioners). The study referred to is by Hogg W. E. et al. *The Case for Small Rural Hospital Obstetrics*. Canadian Family Physician 32: pp.2135-38, October 1986.

54 Submission No. 70, p.4 (Royal Australian College of General Practitioners).

so that epidural anaesthetic may not be available (and because women are less likely to have their labour artificially initiated it may be less necessary). In these circumstances there is greater need for alternative, less interventionist approaches to pain relief and greater knowledge and skill in their use.

4.73 In country hospitals staffing arrangements tend to be less hierarchical than in urban areas. Midwives and general practitioners work as a team. The woman giving birth is likely to have received her antenatal care from the midwife and/or general practitioner attending at the birth. This continuity of care and familiarity with the people attending at the birth have been demonstrated in many studies to increase women's confidence and sense of control during the birth, which in turn reduces the need for intervention.

> The best examples of the whole of the shared care model are in the country…I refer, for example, to Geraldton…Kalgoorlie, and Collie, which is where I come from. We have a population of only 10,000. We do not have a resident specialist, but we have three GP obstetricians, a general surgeon and anaesthetists and our intervention rate is low. It is currently about 10 per cent…So it can be done, and it can be safely done.[55]

4.74 This pattern is not uniform. The Committee was advised of a number of country hospitals with very high intervention rates. They included, for example, the Coff's Harbour Hospital (23.8%), Tamworth Base Hospital (23.7%) and Lithgow (27.1%).[56]

4.75 While giving birth in country hospitals is in many respects a more satisfying experience than giving birth in metropolitan hospitals (at least for healthy women) there are significant problems. Rationalisation of services in rural areas threatens the existence of small country hospitals. Without them, healthy women in rural areas will be forced to travel to major urban centres for their births and will lose the benefits of giving birth close to their homes and families. The National Health and Medical Research Council has cautioned against further centralisation of hospital services.

> While it is imperative that there is sufficient centralisation of services to ensure that expertise can be maintained in each region, attempts to reduce local services for healthy women with normal pregnancies should be resisted unless clear and unequivocal advantages can be demonstrated.[57]

4.76 The Royal Australian College of General Practitioners also pointed out that:

> Once you close those units [obstetrical units in country hospitals] you get this incredible downward spiral. Closing acute services in a small rural

55 *Committee Hansard*, 8.9.99, p.293 (Dr Turnbull, MLA).

56 New South Wales Health Department. *New South Wales Mothers and Babies 1997*, Sydney 1998, p.88.

57 National Health and Medical Research Council. *Options for effective care in childbirth*, p.12, Canberra 1996.

hospital is a disaster because, once you lose your acute services, you effectively turn many of these small rural hospitals into nursing homes.[58]

4.77 In country hospitals which have closed their obstetrics units, but where births still occur, perinatal morbidity and mortality outcomes have deteriorated.

> The New South Wales study found that deliveries continue to occur in hospitals *without* an obstetric unit and will still present unbooked and often in preterm labour. This often occurs in small towns where the units have been closed because of low numbers of deliveries, lack of support services or proximity to larger hospitals. Without the professional expertise of a functioning obstetric and midwifery service, perinatal mortality and morbidity figures tend to be suboptimal.
>
> **This highlights the need to keep small rural obstetric units open and to staff them adequately. Rural women will continue to want care closer to home and have every right to expect a safe, accessible service.**[59]

4.78 The greatest threat to the quality and safety of the birth experience for country women is the shortage of general practitioners qualified in obstetrics. Many of them are leaving country practices. Of those who remain, many are refusing to undertake obstetrical work. And new entrants are not moving to country areas in sufficient numbers to replace them, despite Commonwealth incentives to encourage them (as described in chapter 2).

4.79 Litigation or the perceived fear of litigation, and the associated costs of insurance are major issues for general practitioner obstetricians in country areas (although State governments subsidise the costs of their insurance). They have contributed to the virtual elimination of specialist obstetricians in rural areas.

> The costs of indemnity for specialist obstetricians is predicated on their seeing enough patients and earning enough income to cover these costs. Especially, away from the big cities, specialist obstetric practice rapidly becomes non-viable. The simple solution for Obstetricians is to limit themselves to only Gynaecology, which is lucrative, has better hours and smaller indemnity bills. This is not the best outcome for the community.[60]

4.80 However, a recent Victorian study suggested that lifestyle issues were an equally important factor in the drift of general practitioners with obstetric training from the country.

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58 *Committee Hansard*, 8.9.99, p.323 (Royal Australian College of General Practitioners).

59 Submission No. 70, p.5 (Royal Australian College of General Practitioners). The NSW study referred to is by Woollard L. A. and Hays R. *Rural Obstetrics in NSW.* Australian and New Zealand Journal of Obstetrics and Gynaecology, 33:3 pp.240-42, 1993.

60 Submission No. 65, p.1 (Dr Joanna McCubbin, Vic).

> Personal/family reasons or interference with lifestyle were chosen by 36% of respondents as the most important reason for ceasing obstetrics. Rising insurance premiums was the reason for 16%, concern regarding the management of unexpected emergencies for 10% and lack of remuneration for 8%…Both rural GPs and urban/provincial GPs considered personal, family and lifestyle issues as the most important (29% v 40%).[61]

4.81 This view was supported by general practitioners in submissions and public hearings.

> Rural Obstetricians may not have the lifestyle, financial and continuing educational opportunities of their city colleagues, so there need to be incentives to keep them or we run the very real risk of losing these services completely.[62]

* * *

> There were two major reasons why general practitioners drop obstetrics, and they are not what you might think. The first one concerned personal family and lifestyles issues. Obstetric practice is very intrusive; it is intrusive on your personal life, your family life and the rest of your medical practice. So when it is not the core business of your medical practice…you tend to look at things you can get rid of, and obstetrics is one of them. People do obstetrics for the love of it.
>
> The second reason people are looking at ceasing obstetric practice…is the rising insurance premiums. A third reason is the perceived threat of litigation. There was, in fact, another major issue that we looked at: being able to get back-up in an emergency. This fear of being alone with an emergency is something that is very high in the minds of general practitioners. It is not the litigation; it is the fear of not being able to cope with an emergency in an isolated place.[63]

4.82 The impact of litigation on the obstetrical work force in country areas is discussed in chapter 10.

4.83 The number of midwives in country areas is also declining. In the period 1993-1996 the percentage of midwives in capital cities increased from 65.8% to 69.2%. In all other geographical locations it declined during this period.[64]

> There are significant problems facing rural and remote Australia in the growing shortage of midwives which places pressure on the continued provision of rural obstetric services.[65]

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61 Innes, Kathleen M. *Why are general practitioners ceasing obstetrics?* Medical Journal of Australia, vol. 166, 3 March 1997.

62 Ibid, p.2.

63 *Committee Hansard,* 8.9.99, p.330 (Royal Australian College of General Practitioners).

64 Australian Institute of Health and Welfare. *Nursing labour force 1998,* Canberra 1999, p.58.

4.84 Commonwealth and State governments have a number of initiatives in place to address this problem and the related problem of ensuring that rural midwives maintain their skills. They include the Commonwealth funded Midwives Upskilling Program, begun earlier this year, through which the Commonwealth will pay State and Northern Territory governments $3,000 per rural/remote midwife so that they can undertake retraining for two weeks every two years. Joint programs with the West Australian and Queensland governments also focus on retraining for rural and remote midwives.[66]

4.85 In addition, the Committee was advised of a number of State funded programs designed to develop the skills of rural midwives. The Royal North Shore Hospital, for example, advised of a midwifery exchange program through which midwives from the Far West Area Health Service of New South Wales have worked for three weeks in the North Sydney Area Health Service.[67] Midwives from the Royal North Shore and Manly hospitals have replaced them at Bourke, Walgett, Wilcannia and Broken Hill hospitals.

4.86 The decline in the rural obstetrical work force and the threatened closure of small hospitals jeopardises the opportunity for healthy women in rural areas to give birth close to home. They may be forced to choose between home birth and transfer to major centres. Neither option is desirable. Home birth in rural areas, even for healthy women, carries an inherent risk because of the difficulty of obtaining rapid assistance in an emergency. Transfer to a metropolitan centre is disruptive to the woman and her family. It is costly and may result in a less satisfactory birth experience, given that she will be in an unfamiliar setting and attended by people unknown to her.

Birth in rural and remote areas for Aboriginal and Torres Strait Islander women

4.87 Many of the issues identified above as applying to women in rural and remote locations apply also to Aboriginal and Torres Strait Islander women. For this group however the position is particularly difficult because they live in the remotest areas where the problems discussed above are most acute. Their own health and diet is generally less satisfactory than that of the rural population as a whole. As noted, they tend to be younger, poorer and have more babies more closely spaced than does the non indigenous population. In addition they face language and cultural barriers in accessing services. All these factors contribute to their poorer outcomes in terms of perinatal and maternal morbidity and mortality.

4.88 Because a greater proportion of Aboriginal women are deemed to be at risk than is the case for the general population, more of them are transferred to urban centres for their births. In the Northern Territory in 1994, for example, nearly 30% of Aboriginal women had to travel away from their homes to give birth. While such a

65 Submission No. 69, p.31 (Women's Hospitals Australia and Australian Healthcare Association).

66 See Submission No. 97, p.31 (Department of Health and Aged Care).

67 In Submission No. 150, pp.11-12.

practice may be justified on purely medical terms, its costs are significant in financial and emotional terms.

> Transferring women from remote locations to hospital to give birth is certainly the safest option from a medical perspective, especially with high-risk pregnancies. Nevertheless this causes significant disruption and anxiety for women and their families, as many women living in remote locations have to travel long distances to the nearest town with birthing services, then wait (sometimes for weeks) for confinement. While birthing in remote locations may not be feasible or safe, provision of more accessible services may be.[68]

* * *

> Let us take the example of Halls Creek in Western Australia, where Aboriginal mothers are shipped out to Derby, which is hundreds of miles away. They go by plane and then the poor things are dumped on a bus with their babies to bring them back to Halls Creek. It is really tragic.[69]

4.89 Some attempts have been made to assist women who are awaiting the birth of their babies far from their homes and families. Each State and the Northern Territory has a 'patient' assistance travel scheme, but this does not usually include travel costs for an accompanying family member. In Cairns, the Commonwealth is funding a special residence for those women, where they can stay with their immediate family, receive culturally appropriate antenatal care and be close to medical attention should they require it. Such an approach is especially helpful for young Aboriginal women, who are particularly vulnerable in large unfamiliar cities.

4.90 For indigenous women at low risk who remain in rural areas to give birth, some innovative approaches to culturally appropriate services were developed under the auspices of the Alternative Birthing Services Program. These include the Alukura Birthing Centre at Alice Springs, referred to earlier, which allows traditional practices within a medically safe environment and the Koori Birthing Support Service at Ballarat, operated by the Ballarat Community Health Centre and the Ballarat and District Aboriginal Cooperative.

4.91 For most healthy Aboriginal women however there are few culturally appropriate services in country areas, or indeed in metropolitan areas. Where there are no qualified general practitioners they are obliged, like women at high risk, to transfer to urban centres.

4.92 One response to the lack of culturally appropriate birthing services is the movement for birth on the homelands. But few Aboriginal women choose this option because no back up health support is currently available for those who do so. In 1996 only 2% of recorded Aboriginal births took place in locations other than hospitals and

68 Submission No. 97, p.33 (Department of Health and Aged Care).

69 *Committee Hansard,* 8.9.99, p.294 (Dr Hilda Turnbull, MLA).

these were mainly in designated birth centres or in bush clinics in the Northern Territory.[70]

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to assist Aboriginal and Torres Strait Islander women who have to give birth outside their communities by funding an accompanying family member, with funding provided through their patient transfer assistance schemes.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government, through the Office of Aboriginal and Torres Strait Islander Health, fund culturally appropriate birthing services, either in hospitals or stand alone, in centres with large Aboriginal and Torres Strait Islander populations.

70 See Australian Institute of Health and Welfare. *Indigenous mothers and their babies Australia 1994-1996,* Sydney 1999, p.12.