Article

Access to Maternity Services and the Ethical Implication of Policy Implementation

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Sixty years after introducing a comprehensive health care system that involved providing free good-quality maternity care to all mothers, New Zealand has embarked upon a course that many believe to be both experimental and unethical.

On 15 May 1939 New Zealand women were granted access to free medical and hospital services for maternity care. This development followed on from the passing of the Social Security Act in 1938 that saw the introduction of New Zealand's free health services, including the provision of free maternity care for every woman from the doctor of her choice. For sixty years New Zealand women have been provided with free antenatal, labour and birth and postnatal care, and free hospital care in public maternity hospitals. They have also enjoyed access to domiciliary midwifery services and maternity care from GPs – both at no charge. What this has meant is that since 1939 doctors and midwives have not been permitted to make extra charges to the woman above what they are paid by the state when providing them with maternity care.[1]

On 1 July 1996 major changes were introduced to the provision of maternity care in New Zealand. One of the results of these changes has been the first major move away from this strong tradition of providing all women with access to free maternity care. Whether this was intentional on the part of those who developed and implemented the new system is uncertain. What we can be sure of is that since the introduction of the new payment system the government has shown little interest in doing anything about the introduction of charges for maternity care traditionally provided to women without cost.

The impact of these changes in terms of the loss of free maternity services was seen most dramatically in Auckland, where several groups of GPs began charging for maternity care, many obstetricians started charging for midwifery care by openly including this as an item on their bill, or simply increased their fees, and where New Zealand's largest public maternity hospital recently implemented the extraordinary idea of a fee-paying postnatal ward for women who could afford to pay for extra 'hotel-type' services. Given the Minister of Health's low-key reaction to the news of National Women's Hospital's *Cornwall Suite* it is highly likely that other maternity hospitals will follow suit.

Women report other problems with the new system, including difficulties finding a lead maternity caregiver (LMC), or not being able to have the provider of their choice. Rural women have had, and continue to have, even fewer choices. Given that the new system was promoted heavily to women as being one that would offer them more choice, it is unsurprising that they find the current situation totally unacceptable and have complained loudly.

The new funding arrangements have also served to foster or exacerbate hostile relationships between maternity care providers. The history of some of this hostility can be traced back in part to the introduction of the Nurses Amendment Act in 1990, which resulted in midwives being able to practice independently of doctors when providing primary maternity care to women. This dramatic change resulted in a fairly predictable reaction from GPs who regarded independent midwives as a threat to the monopoly they had formerly enjoyed as primary maternity care providers. It also resulted in a climate of resentment and a lack of co-operation between hospital and independent midwives.

Five years down the track the dust had begun to settle, and GPs and midwives were starting to team up to provide women with continuity of care in the context of various birthing philosophies; for example, those practitioners who specialised in home births, or promoted low tech hospital births, and those whose philosophy resulted in a more interventionist-style of birthing. Women were able to choose caregivers whose philosophy matched their own preference for the birth of their child. The new funding arrangements introduced in 1996 blew these still tentative and rather fragile alliances completely out of the water. These changes enabled the competitive model of health care to reassert itself with a vengeance, and over the past three years pregnant women have been the losers. For example, in the surveys of women's experiences of maternity care undertaken by the National Health Committee as part of its review of maternity services, women reported that disputes between their maternity care providers during birth were causing them considerable distress.

Questions must be asked about the ethics of introducing a maternity care system which promotes disputes between caregivers and the kind of undesirable scenarios in which women become the meat in the sandwich while giving birth, surely a time in their lives when most vulnerable. A health care system that promotes competition is one thing, but deliberately introducing funding arrangements for maternity care that are almost guaranteed to create hostile and potentially dangerous situations for birthing women, is another.

It needs to be acknowledged here that tension has always existed between those health professionals who advocate and promote natural birth and support a woman's right to choose how and where she gives birth, and those who believe that birth is normal only in retrospect and that all women should give birth in hospital and be monitored and managed. The history of women's efforts to reclaim birth includes the formation of a number of consumer groups such as Parents Centre and the Home Birth Association which have arisen to provide women with information and support, as well as access to alternatives to medical management and domination of the

birth process. These organisations succeeded in finding health professionals who would support women wanting to give birth at home or in hospital with little or no unnecessary medical intervention. Sympathetic and supportive midwives and GPs were often vilified and alienated from their colleagues as a result of their non interventionist approach to birth.

However, by the late 1980s there had been a considerable increase in the numbers of doctors and midwives who were prepared to support women's birthing choices and most hospitals had been forced to adopt a more conciliatory approach to women's desire to have more control over their birthing. This rapprochement stood doctors and midwives in good stead when midwives regained their status as autonomous practitioners in 1990 and a great deal of goodwill disappeared out the door. Given the history of fraught relationships between provider groups, the subsequent introduction of 1996 funding arrangements seems even more reprehensible.

Another worrying aspect of the current system is the gradual whittling away of many of the things women had come to take for granted when accessing maternity care. For over a decade there have been ongoing protests from consumer groups and individual women about the fact that the maternity care system is no longer providing women with access to free good-quality care during pregnancy, birth and postnatally. A lack of postnatal care and support in particular has been one of the major themes of these protests.

What is now emerging is the development of a two-tiered system of maternity care in which the majority of women get a very basic level of care and those who can afford it get a service with highly desirable extras. For example, most women are now being *encouraged* (read pressured or coerced) to leave hospital a day or two after giving birth, a policy that has been described as experimental and potentially harmful especially when there is insufficient follow-up community care. Most women receive little or no support or home help apart from five to ten midwifery visits. Recent surveys by the National Council of Women, the Health Funding Authority and the National Health Committee reveal that many women get less than five visits and that they are not at all happy about this. However, the introduction of private services using public funds now means that among other things those women who can afford to pay hundreds of dollars for 'hotel-type extras' get to stay in hospital as long as they wish, getting the kind of care that all new mothers should have.

It must also be pointed out that those mothers with the greatest need for extra care and support in the first few weeks of motherhood – very young mothers, single mothers, women coping with inadequate housing, unemployment, insufficient income, and a great deal of stress – are those getting the least services. The emergence of private postnatal care which offers good food, the presence of family members, extra midwifery care from experienced midwives, privacy, clean en suite bathrooms and the removal of any form of pressure to leave, highlights the iniquity of a system which provides luxuries for a fortunate few and an unacceptably low level of postnatal care for those most in need of it.

The underlying agenda of privatisation raises issues of major concern to many New Zealanders, and although the maternity service is just one of the services that is now becoming increasingly privatised, there are significant differences between maternity care and other health services. A lack of care during pregnancy, labour and birth, or during the postnatal period can impact on the health and well being of mother and baby and result in critical or chronic conditions that may take months or years to become evident or be resolved. For example, breast feeding provides significant health advantages to both mother and baby, bestowing the baby with protection against infection, reducing the risk of sudden infant death syndrome (SIDS), as well as conferring many other long term health benefits. It therefore makes good sense to put in place a system of care that promotes breastfeeding by providing women with the postnatal care and support they need to establish and maintain breastfeeding. There is growing evidence that many women are not getting the support they need and increasing numbers are choosing not to breastfeed or are giving up in frustration.

Although private maternity hospitals have always existed in some parts of the country, the majority of women in New Zealand have had their babies in public hospitals and have been provided with a high quality service that, prior to 1982, entitled women to spend up to two weeks in hospital following the birth. During this time women learned how to breastfeed and were taught how to hold, bathe and care for their babies – skills referred to as mothercraft.

Suddenly, without any form of public debate, women are being pressured to leave hospital a day or two after giving birth and well before breastfeeding is established, and public money is being used to contract with private maternity care providers and to set up private fee-paying facilities in public hospitals. That the government is quite happy with this arrangement was made obvious when the Minister of Health expressed his annoyance at not being advised earlier of National Women's Hospital's plans to set up a private postnatal ward. The ethical issue of the hospital spending approximately half a million dollars of public funds to refurbish the former delivery suite and of charging women to stay in a public hospital seems to have completely escaped him.

That so many women are prepared to pay to stay in hospital is in itself an indictment of the current state of maternity services in New Zealand. Surveys and anecdotal evidence reveal that women up and down the country are not happy at being compelled to leave hospital before they feel ready. Add to this the fact that hospital postnatal care is so inadequately funded that women report having to bring in their own sanitary napkins, toilet paper and nappies.[2] Plunket Family Care Centres are struggling to cope with desperate women turning up on their doorsteps, some with babies only a week or two old.

Health has now become an individual's responsibility, having children is a 'lifestyle choice', and we live in a society that is not child or family friendly, and does not value the work women do in having and raising children, preferably out of sight. Our maternity services now appear to be reflecting such philosophies. But is this what we really want?

Notes

1. Donley, J. (1986). *Save the Midwife*, New Women's Press, pp 47-8.
2. Reports from women attending plenary session at Parents Centres NZ conference in Auckland, 17–20 September 1999.