‘New midwifery’ in Australia: what kind of professionalization is likely to emerge from current processes of change?

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Abstract
Australian maternity services are divided between public and private sectors and differ between States and regions. A 2009 Commonwealth review proposed a greater role for midwives in primary and cooperative care and opened Medicare funding for private practice within certain limits. This paper addresses the type of professionalizing project being envisaged in Australia based on an analysis of the publicly available submissions to the review. These were downloaded from the websites of the Commonwealth and various professional organisations and analysed thematically. Major issues arising from the submissions were the predominance of a ‘new midwifery’ identity whilst conceding the complexity of midwifery in Australia; the distinctively Australian demand for State support of private midwifery practice; the invisibility of much publicly funded midwifery innovation; and the strategic use of evidence by different professional groups. The paper draws attention to contradictions in the type of midwifery professionalization envisaged in the submissions especially between ‘democratic egalitarian’ models of professionalism and traditional ‘social trustee’ autonomy. It notes some divergence in the submissions of medical organisations and concludes that it is publicly funded midwifery practising within co-operative guidelines which is more in accord with neo-liberal models of governance backed by the contemporary state while private practice midwifery shares more in common with a traditional model of professionalism.

Keywords: professions, midwifery, maternity service reform, neo-liberalism, social democracy, inter-professional relationships.
Background
This paper examines Australian midwifery in the context of contemporary policy changes and is intended as a contribution to the international de-centred comparative study of maternity services (Benoit, Wrede et al. 2005; Wrede, Benoit et al. 2006). Maternity services in Australia are located in a complex system divided between public and private sectors and state and federal jurisdictions (Sax 1984; Australian Institute of Health and Welfare 2010). One of the complexities in this system is the pressure to reform health care using neo-liberal forms of governance (Bryson and Verity 2009; National Health and Hospitals Reform Commission 2009). After a generation of advocacy by consumer and professional groups (Lane 2000-2001; Reiger 2000-2001), maternity service advocates finally found a hearing by the 2007 Rudd Labor Government and the focus of this paper is on the implications for midwives and midwifery professionalization for this process. The Australian government, like other social democracies subject to neo-liberal policy influences, may extend the roles of allied health professionals, including nurses and midwives as a way to reduce health costs as well as respond to consumer demand (Reiger 2006; Willis 2006).

The professional role and identity of midwives in the Australian maternity system is comparable but not identical to that of midwives in other English speaking nations. In comparison with the UK and New Zealand, Australian midwifery has been more closely associated with nursing since the 1920s and there has been no separate midwifery training or registration until the present century. During the 20th century Australian midwifery was virtually a sub-specialty of nursing but was not excluded and rendered illegal, as was the case in the USA or Canada. However, Australian midwives had less autonomy, even within a limited sphere of practice, than midwives in Britain and Europe (Pincombe, McKellar et al. 2007). This is largely because of the prevalence of private practice obstetrics which has been the most common and highly-regarded type of maternity care (Zadoroznyi 1997; Cameron and Ellwood 2006). As in the United States where private obstetric care is also common, it has been the practice for normal pregnancy to be under the supervision of a specialist obstetrician. Midwives were more involved in the care of public patients but always under the
supervision of specialist or junior doctors (Reiger 2001).

As in Canada and the US, the marginalisation of midwifery practice combined with a counter-cultural movement has produced a range of alternative midwifery practices outside nursing. These independent midwives argue that they have escaped medical domination and are to be recognised as ‘real midwifery’ as opposed to obstetric nursing (Umansky 1996; Murphy-Geiss, Rosenfeld et al. 2010). Unlike Canada where there has been recognition of apprentice-trainee midwives and the US where there is a range of training and certification available (Bourgeault, Benoit and Davis-Floyd 2004; Davis-Floyd and Johnson 2006), Australian non-nurse midwives must go through “direct-entry” midwifery training at University. It can be seen that the combination of social democratic welfare provision, free market private practice and libertarian alternatives produces a high degree of complexity in the Australian midwifery policy landscape.

There are important and controversial developments occurring at present which may change this picture. A new national regulatory framework provides for uniform registration for nurses and midwives across State boundaries and institutionalises the separate training of midwives and nurses. The recent Review of Maternity Services (Commonwealth of Australia 2009) proposes a greater role for midwives in primary and cooperative care which would endorse the work of midwives in the public sector. The review also suggests Medicare reimbursement for private midwifery practice within certain limits as well as supporting professional indemnity insurance for some private midwives (Commonwealth of Australia 2009; Wilkes, Teakle et al. 2009). Willis (2006) suggests that the granting of Medicare provider numbers is a significant development in the relationship between medicine and other professions. The granting of access to Medicare by midwives in Australia promises to alter what has been described as the double subordination of Australian midwifery to both medicine and nursing (Willis 1983).

Professional subordination cannot be divorced from issues of public and private practice and in particular the issue of scope, guidelines and protocols to promote safe midwifery practice. Discourses of professionalism in Australian midwifery are complex. Much of the research and advocacy for the ‘new midwifery’ as well as
service innovation is located by midwives who are salaried either as academics or within public hospitals run by salaried midwives (Brodie and Homer 2009). Much of the support for private practice midwifery comes from supporters of home birth who are wary of government regulation and cooperation with the medical profession. This means that the midwifery professionalising project is internally divided which affects its negotiation with the state and other professional groups.

**Diverse types of professionalism and professional identity**

This paper addresses the type of professionalizing project being envisaged in debates over Australian midwifery. In his classic study of the achievement of medical dominance in Australia, Willis (1983) described midwifery as ‘doubly subordinated’ because it was absorbed into nursing rather than having a separate professional register and the nursing profession was already institutionally dominated by medicine. It appears that Australian midwifery has to a certain extent gained some support of the State for its challenge to subordination. It is also noted that discourses of professionalism and professionalization are also a resource for the creation of solidarity and identity (Evetts 2003). The question is what kind of professional power, autonomy or identity is likely to emerge from the present negotiations around Australian midwifery.

In their ‘de-centred’ comparison of social welfare democracies, Sandall, Benoit and their colleagues (2009) criticise the prevailing definitions of profession as unduly tied to the classical work of Friedson because, they argue, this type of ‘social trustee’ professionalism presumes a free market in medical services. In social welfare systems, social service professionalism is deployed more for the welfare of the public health or the society as a whole rather than in relation to individual relationships between doctors and patients. They point out that both these types of professionalism have been heavily under patriarchal influence and contributed to a hierarchical view of health occupations particularly disadvantageous to the professional projects of female dominated occupations like midwifery.

Sandall and colleagues also point out that Nordic countries have developed an egalitarian ethos of empowering patients and other occupations; this is described as
Democratic Professionalism. Lastly, it is suggested that professional qualifications in neo-liberal states have acquired the attributes of portability and flexibility which encourage practitioners to employ their qualifications as assets in the free market. (Sandall, Benoit et al. 2009).

This typology of professions is of interest in the analysis of Australian midwifery because of the mixture of the free market, exemplified by private obstetric practice, and the social democratic system which produced universal access to care under Medicare. New midwifery which defines itself as ‘woman centred care’ is an international movement which lays claim to characteristics of democratic professionalism and demands more egalitarian inter-professional relationships with medical colleagues. There is a tension here between the types of autonomous practice which were the traditional attributes of professions and the audit, regulation and surveillance required in neo-liberal systems of governance (Power 1997; National Health and Hospitals Reform Commission 2009).

Method
The paper is based on an analysis of the publicly available submissions to the 2009 Commonwealth Review of the maternity services. Where the authors consented, submissions to the Maternity Services Review were posted on the Commonwealth site until 30th June 2009. These public domain documents were available for analysis without ethics clearance. The submissions of relevant medical organisations, the AMA, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and Royal Australian College of General Practitioners (RACGP) were available from the organizations’ own websites.

All documents in Word and PDF format were imported into QSR NVivo. Submissions were classified as Professionals (39), Organisations (79) and Individuals (492). This paper draws on professional and organisational submissions, including voluntary and not-for-profit campaign, support, advocacy and educational groups. Submissions were read and coded in their entirety and the codes were grouped in the course of analysis to produce themes relevant to the research. These were midwifery identities, the role of the state, evidence, autonomy and inter-professional relations.
Findings
The position paper which called for submissions to the review was identified quite clearly as in favour of an increased role for midwifery in the provision of maternity services. This identification of the enquiry as a ‘midwife’s charter’ may account for the absence of medical submissions posted to the review website and the almost total absence of any critical comment in the submissions which were posted.

Midwifery identity
The majority of the submissions identified midwifery as an autonomous profession and appealed to international evidence supporting the definition of a midwife as a specialist in normal birth with the ability to make referrals where needed, rather than to have work delegated to them:

As specialists in normal pregnancy and birth, midwives can provide high quality care to women, with referral to medical services, as needed, utilising the evidence-based Australian College of Midwives National Referral Guidelines. International experience indicates that 70-80% of women can receive primary midwifery care, with the remainder receiving collaborative care from obstetricians, while retaining low maternal and peri-natal mortality rates (152 Midwifery organisation).

However it was noted that midwifery in Australia is segmented in terms of its skills and values:

the skills and knowledge of the midwifery workforce appears fragmented with some midwives being apparently very good and others being less skilled with ‘old fashioned’ ideas (462 Author and men’s group).

Role of the State
The submissions from these overwhelmingly committed supporters of midwifery were unanimous in their belief that the Australian Government had a role in the extension of midwifery services. The belief that the State has an obligation to provide a full range of services would be shared by most European and English speaking social democracies, but Australian contributors also argue that the State can and should support private practice midwifery, including homebirth.
A SAFE, personal, cheap for the government, fully informed, natural birth in the comfort of their own home. Their birth – their way. This quality of service is the right of every Australian woman and the responsibility to provide by the Australian government (074 NGO - emphasis in the original).

In the context of the fee for service system operated by the medical profession, midwifery advocates and professionalising midwives argued strongly that this should be done by reimbursing fees for private midwifery through Medicare and by underwriting professional indemnity insurance for privately practicing midwives. Granting these privileges, which has rarely been done for any health occupation, challenges the monopoly of the medical profession and promotes midwives as autonomous professionals. While this is drawn from the ‘social trustee vocabulary’, this contributor utilises the neo-liberal language of competition policy to justify the support of private midwifery:

The Government needs to address this discriminatory and anti-competitive approach to insurance in Australia. Once insurance for midwives in private practice is addressed, this part of the market will expand, reducing the financial burden on hospitals (462 Author and men’s group).

This comment reflects a common Australian expectation that the government is expected to ensure equity for those who choose to use private services because they are understood to be ‘taking the pressure off the public system’ rather than diverting resources from it as might be seen in other countries. New midwifery is associated with the provision of ‘continuity of care’; in the submissions this was strongly associated with private practice rather than new public models of midwifery which are said to be available only to a minority.

I would love to see the day when a woman can be privately insured, choose an independent midwife much the same way she can choose a private obstetrician at present, and then choose to birth in either a public or private hospital with her independent midwife. (014 Midwife)

Continuity of midwifery care was also most frequently associated with homebirth, rather than midwifery led public hospital care:
As you are aware midwives in private practice who attend birth at home, provide the only true midwifery care in Australia. That is, one to one midwifery care through pregnancy, labour, birth and post-natally up to six weeks postpartum. (006 Midwife).

These aspirations are for a type of democratic professionalism which responds to the desires of clients and equalises power relations. However, the means by which this is to happen is very different from the Nordic model of universal public provision; rather there is an aspiration to the level of private practice rights enjoyed by the medical profession under a social trustee model. This also differs from the ‘new public midwifery’ and appears to avoid the level of governance by guidelines and accountability demanded by the neo-liberal state which is promoting the change.

**Evidence, autonomy and professional relations**

The claim for professional autonomy is based on an appeal to evidence; it is clear that evidence is used strategically both for and against increased autonomy for midwives. Submissions did not acknowledge that the majority of evidence for the effectiveness of midwifery in Australia has been produced by publicly funded ‘new midwifery’ schemes rather than in the private sector. Many submissions cited the Cochrane review of midwifery led care (Sandall, Hatem et al. 2009) without acknowledging that this review does not cover homebirth practitioners. Many contributors subscribed to the view that homebirth must be safe because it avoids unnecessary intervention found in hospital:

Homebirth under this model of care is very safe, if not the safest way in which a woman can give birth. This is for many reasons including continuity of carer, no to minimal interventions (except where clinically appropriate or necessary), sound birth education and antenatal education including teaching the woman self coping techniques, all of which are barely covered in hospital systems (006 Midwife).

While this position was widely supported it continues to be controversial. All the medical organisation submissions highlighted adverse outcomes for Australian homebirth (for example Bastian, Keirse et al. 1998). They also ignored the research about the safety of ‘new midwifery’ in Australia and had minimal reference to
international evidence for the safety and effectiveness of midwifery led models of care which they claimed are irrelevant to the Australian context.

Medical submissions oppose homebirth but concede that there should be standards for its practice. However, their submissions only cite evidence which casts doubt on the safety of midwife led practice and homebirth in particular rather than giving credit for the excellent results produced by midwifery innovation in Australia and elsewhere.

The submissions, which were dominated by advocates of private, independent midwifery practice with a preference for homebirth, appeared to be demanding both the financial support of the State and the granting of ‘social trustee’ professional status for independent midwives in the belief that the evidence supports a wide scope of practice. This position was vulnerable to criticism from the existing holders of professional power, the medical profession, whose submissions were designed to limit and discredit the idea of ‘independent’ midwifery and to bring forward evidence of the danger of homebirth and the importance of not giving public support to midwives who would be encouraged to extend their scope of practice. In the course of arguing this, medical organisations proposed various models of collaborative practice, including not only the public but also the private sector. While the AMA has retained the language of delegation and subordination, RANZCOG and RACGP have changed their rhetoric and see possibilities in advanced midwifery practice acting to ‘extend the reach’ of private obstetrics.

Discussion
In terms of their model of professionalism, advocates of independent midwifery practice have more in common with private obstetricians than with advocates of midwifery services integrated into the public health system; in practice the two groups are firmly opposed to each other, but in terms of their understanding of professional autonomy they have more in common than at first appears. Ironically, espousing this model of autonomy and a breadth of practice claimed by some independent midwives gives medical lobby groups the evidence they need to persuade the government to limit practice and exclude homebirth. While the independent midwifery advocates desire a form of ‘democratic professionalism’ (Sandall, Benoit et al. 2009), their
version of autonomy involves freedom from interference by the state which more closely resembles free market professionalism than its Nordic exemplar.

Public health midwifery appears to have a better claim to democratic professionalism. It has developed a solid body of evidence for the effectiveness of midwifery led care and engages in more dialogue with opponents and on-the-ground negotiation (Brodie and Homer 2009). In addition, the development of referral guidelines (Australian College of Midwives 2003) adds to the legitimacy of midwifery in the context of neo-liberal governance. The heavy emphasis on the issue of Medicare rebates and Professional Indemnity Insurance in the review seems to have downplayed the significance of new models of public health midwifery. It remains to be seen whether the lower profile may allow innovation to continue without the controversy attached to ‘Independent’ midwifery.

**Conclusion**

Promoting public new midwifery requires increased government backing, both financial and in policy terms, for innovative kinds of cooperative care in the public sector. The moves towards supporting private practice emerging from the review may or may not promote greater availability of midwifery and continuity of care. Three quarters of all midwives (AWHAC 2002) are working in the public sector and so do not require government support of this kind. It is ironic that the most vehement struggle over professional autonomy is in the private arena where Medicare rebates and indemnity insurance are relevant to inter-professional relationships and where the fear of homebirth with a wide scope of practice gives ammunition to those who want to keep midwifery subordinate to medicine. Medicare rebates and indemnity insurance are less relevant in the public sector which is covered by vicarious liability and advocates of public midwifery are more willing to develop guidelines and regulations to limit the scope of practice. The professional project of ‘new midwifery’ in Australia is hampered by the complex split between public and private funding and the invisibility of the public system where much of the innovation has taken place.
References


