



Editorial

Since the passing of the Social Security Act 1939 maternity services in New Zealand have been state funded, including domiciliary (home birth) services. Below poverty level remuneration disabled most midwives from surviving in home birth practice¹ until the Nurses Amendment Act 1990. Along with the return of professional autonomy, self-employed midwives then received equal pay with General Practitioners for equal work, and self employment became viable. The progressive closure of small maternity hospitals from the late 1960s has slowed and some new privately owned and operated units have come into being since 1990. There has been a strong message from the Ministry of Health, since at least 1990, that home and low tech hospitals/birthing units are amongst the birth place options from which pregnant women are entitled to choose.

Overt obstetric opposition to home birth in New Zealand has also moderated since the 1970s and 1980s when individual obstetricians and members of the country's Obstetrical and Gynaecological Society demanded the (then) Department of Health explain why tax payers' money was used to pay home birth midwives.¹ There has been no such moderation to home birth for their Australian counterparts however.

Bills currently being debated in the Australian Parliament, will, if passed, exclude midwives providing services during labour and birth at home from Medicare funding and professional indemnity insurance.² Therefore, when the proposed National Registration rules governing midwives in Australia take effect from 1 July 2010, midwives in private practice will be unable to practice as they will not have professional indemnity insurance covering every aspect of their practice.³

These repressive moves have been influenced by, if not able to be directly attributed to, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). In their March 2009 guideline on models of care and criteria for midwives to refer women to obstetricians, RANZCOG states it "does not support home birth or 'free-standing' Birth Centres (without adjacent obstetric and neonatal facilities) as appropriate health care settings".⁴

This is not an evidence-informed position. Decades of evidence show that when well women give birth in high tech environments, inappropriate and unnecessary medical

interventions increase and, as evidenced previously in this journal,⁵ midwifery practice is constrained. Equally well evidenced is the fact that home is a safe environment for birth when well women with uncomplicated pregnancies are attended by skilled birth attendants, that is, midwives.

The Australian membership of the group may be off on their own tangent of trying to control birthing women and midwives but the silence from the New Zealand arm of RANZCOG is disturbing. Perhaps such silence indicates that little has changed in the last 30 years and that only high tech obstetric settings continue to be supported by obstetricians. Women (and midwives) would be well advised to consider this silence may be covert acceptance of the guideline rather than just 'leaving the Australians to do their own thing'.

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References

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