

Roslyn Donnellan – Fernandez

Having a baby in Australia: Women's Business, Risky Business, or Big Business?

Introduction

The political economy of childbirth services supply in Australia is an emerging space worthy of critical consideration by scholars, policy makers and economists. The interests served by current arrangements is a neglected area of scholarship and received perfunctory attention in the federal government review and report, *Improving Maternity Services in Australia* (DOHA, 2009) and the national framework for implementing primary maternity services (AHMAC, 2008). Recent government initiatives include a \$120.5 million maternity reform package announced in the 2009-10 Budget and passage of three Acts encompassing new legislative arrangements for midwives (DOHA, 2010). These entail provision of a Commonwealth professional indemnification scheme and access to the Medicare Benefits Schedule and Pharmaceutical Benefits Schedule for eligible midwives working in collaboration with medical providers (Wilkes, Teakle and Gamble, 2009; NHMRC, 2010). Other key elements include commitment to a National Maternity Services Plan (Australian Health Ministers, 2010), expansion of the Medical Specialist Outreach Assistance Program to rural and remote communities, training support for doctors and midwives and expanding the National Pregnancy Telephone Counselling Helpline (DOHA, 2010). The government claims this reform agenda will improve choice for Australian women seeking high-quality, safe maternity care. However, absence of both gender equity considerations and economic analysis leaves this open to question. Data linkage including analysis of health outcomes and cost of services delivery on which to base future policy and sustainable health reform would seem prudent.

This paper seeks to explore the haphazard impact of existing maternity service arrangements and interests on women both as non homogenous individuals and as groups, to stimulate consideration of new possibilities. Toward these objectives the paper asks three rhetorical questions: Is having a baby in Australia women's business? Is having a baby in Australia risky business? Or, is having a baby in Australia integrally connected to big business, including protection of entrenched financial interests in the health sector? It is asserted that the social construction of pregnancy, childbearing and mothering, including service "choices" and current arrangements available for having a baby has much to do with the intersection of each of these three questions. Further, that focusing the lens of gender equity (Bacchi, Eveline et al., 2010) collectively upon these issues can provide an integrated consideration of what is a confused picture for many women and their families. This analysis may also assist current and future governments in planning and implementing maternal health policy based on sustainable service and system reform that improves equity and access for all women and their babies in Australia (Reibel, Vernon et al., 2002; Donnellan – Fernandez, Newman et al., 2008; Maternity Coalition, 2008, 2009; Banks, 2009; Boxall and Buckmaster, 2009; Benoit, Zadoroznyj et al., 2010).

Key themes: women's business, risky business, big business

Having a baby is women's business and strongly bound to gender and culture. This claim is made on the basis that it is woman who is pregnant and woman who gives birth through her body. The identity, role and status of woman is mediated through cultural, social and individual meaning and expectations (Jordan, 1993; Davis-Floyd and Sargent, 1997; De Vries, Benoit et al., 2001; Bryant, Porter et al., 2007; Campo, 2010). These factors are influenced by intersecting social determinants of health (Commission on Social Determinants of Health: 2007). Equally important are relationships, environment, technology and structural interests that influence pregnancy, childbearing and childrearing in modern industrial economies. Feminist scholarship demonstrates that these interests and relationships are frequently complex and contested (Oakley, 1976; Oakley, 1984; Shachar, 2001; Cherniak and Fisher, 2008). These tensions are also evident in the women's movement in Australia (Reiger, 2001). In a liberal, democratic society strong assumptions and expectations exist in relation to woman's reproductive rights and assertion of bodily autonomy. This includes her agency for self determination in accordance with international declarations on reproductive rights and conventions for the elimination of discrimination against women (UN, 1979; UN Economic and Social Council, 2000). There is also strong social and systemic expectations of safety (Kildea, Pollock and Barclay, 2008). In Aboriginal communities this has always encompassed a requirement for cultural safety, whereby birth should take place according to cultural law and traditions that maintain ties to country and a sense of belonging, The Grandmother's Law (Carter and Hussien, 1987; Rawlings, 2002; Kruske, Kildea and Barclay, 2006). Attention to culturally appropriate primary maternity services is not widespread in Australia (Kildea, Kruske et al., 2010).

Secondly, this paper asserts that social and medical construction of pregnancy and birth as 'risky business', rather than recognition and promotion as a 'physiologic, healthy life event for the majority of women and babies', actively contributes to maintaining a medico - centric hegemony of current structural service arrangements in Australia. Consequently mainstream 'options' for health care are determined within 'risk assessment' frameworks that privilege biomedical dominance of services, accessibility, funding and delivery, including control of policy and processes that maintain the status quo (Raymond, Hartz and Nichol, 2008; Skinner, 2010). Some propose that the maternity health system is itself a social determinant of health (Newman, 2008a). Continuing ambivalence toward addressing issues of cultural safety in policy and practice in mainstream services is contrary to the interests of the majority of healthy women and babies and dangerous for many others (Kildea, 1999; Kildea, 2006; Kildea and Wardaguga, 2009: 281).

Thirdly, pregnancy and birth in Australia is big business. Neo- liberal economic policy and funding structures that positively discriminate toward privatized health services have increased here as elsewhere (Baker, 2005; Reiger, 2006; McAuley and Menadue, 2007). This trend continues to dominate health policy and funding agendas, public debate and reform initiatives which appear preoccupied with fee for service models (Benoit, Zadoroznyj et al., 2010: 476). Evidence demonstrates that increased privatization of maternity care does not deliver improved health outcomes for women or babies (Roberts, Tracy and Peat, 2000; Shorten and Shorten, 2000; Shorten and Shorten, 2004; Tracy and Tracy, 2003; Tracy, Wang et al., 2007a; Guilliland, Tracy and Thorogood, 2010). Significantly, recent reports on maternal health in the United States (Sakala and Corry, 2008; Amnesty International, 2010) demonstrate clearly how an affluent country with a modern health system which is largely privatised has come to be ranked fortieth internationally in

maternal mortality and morbidity. Whilst the Australian health system has significant structural differences to the US, including a strong public health sector, one of the key messages of this paper is the correlation between health system features, particularly increasing privatization and increased surgical birth interventions, linked to higher morbidity and mortality for women (Amnesty International, 2010: 85). Despite longstanding citizen advocacy to reverse these trends in the US, the evidence is that systemic failure and flawed policy have prevailed (CIMS, 1996; APHA, 2001; Childbirth Connection, 2009).

Current evidence indicates that in Australia birth in private hospitals has been increasing since 2000. This correlates strongly with policy implementation designed to increase uptake of private health insurance (Benoit, Zadoroznyj et al., 2010: 478). According to national data (Laws, Li and Sullivan, 2010) and multivariate studies, if you are among the 46% of Australian women who hold private health insurance and attend a private doctor and private hospital for your birth the statistical likelihood of operative delivery via caesarean section doubles (Van Gool, 2009a; Benoit, Zadoroznyj et al., 2010: 479). Whilst explanation for this varies (De Costa, 2008; Hamer, 2007), studies show the higher rates in private hospitals is not explained by features associated with the woman such as increased risk profile or birth complications (Roberts, Tracy and Peat, 2000; Shorten and Shorten, 2004). Research shows that women undertaking care through the private sector also undergo higher rates of episiotomy (Shorten and Shorten, 2000) in addition to higher rates of instrumental birth (Laws, Abeywardana et al., 2007: 39). This higher incidence of interventions in healthy women and babies is not associated with improved perinatal outcomes, but with increased risks for these mothers and babies (Roberts, Tracy et al., 2000) and increased costs (Tracy and Tracy, 2003). Comparative analysis of the effect of neo liberal policy in maternal care in Canada and Australia provides strong evidence that similar trends in both privatisation and increasing surgical intervention in birth in private hospitals, will challenge future health care outcomes of increasing numbers of mothers and babies (Benoit, Zadoroznyj et al., 2010: 479). Given current rates of caesarean birth in Australia, approximately one woman in every three (Laws, Li and Sullivan, 2010), this is an important public health issue. Correlation between increasing fee for service models and increased medical intervention in childbirth, including known social and economic gradients associated with these trends pose significant equity challenges to those advocating incremental maternity reform (Boxall and Flitcroft, 2007), as well as to those guiding broader health policy and systems reform in Australia (Boxall and Buckmaster, 2009).

Each of the themes above encompasses gender equity considerations which are critically emerging spaces in our society. In Australia it is timely to address four key issues:

- a) continuing social and professional control of women during pregnancy and childbirth;
- b) equity and access of supply, quality, cost, accountability and disparity in outcomes delivered by services for different groups of women and babies, including continued growth of privatized services;
- c) 'moral hazard' whereby risk construction, assessment, and definition confine options, enforce authoritative knowledge claims, and limit agency in pregnancy, birth and parenting;
- d) commodification of women's and babies bodies to satisfy the interests of privatized health markets.

Within these spaces, intersection of neo liberal health policy, market ideology, consumer choice rhetoric and Saul's (1997) concept of "Unconscious Civilization" are all relevant considerations.

Maternal and infant health: International and Australian contexts

The health needs of mothers, the newborn and children cannot be left unmet without harming the whole of society (WHO, 2005). Whilst the international policy context for maternal and child health is framed within the United Nations Millennium Development Goals (2010) the Eleventh Annual State of the World's Mothers Report (2010) indicates that levels of maternal mortality in many developing nations has not changed significantly in the last 20 years (Save the Children, 2010). However, reductions in maternal and infant mortality has been achieved in countries that have made women's and children's health a priority utilising existing low cost solutions (WHO, 1996; WHO, 2005). These gains challenge beliefs that large numbers of maternal and child deaths are inevitable or acceptable (Gates, 2010). In 2009 the International Initiative on Maternal Mortality and Human Rights (IIMMHR) produced a report exploring the relevance of civil society budget analysis and its potential to hold governments accountable in both reducing maternal mortality and in making maternal health a budget priority (IIMMHR, 2009). This strategy is relevant for both developing and developed nations.

Whilst Australia ranks as the second best place in the world to be a mother with the Review of Maternity Services emphasising that it is one of the safest countries in which to have a baby (DOHA, 2009), this is a view that requires qualification in relation to specific realities of service provision, funding and distribution, including differential outcomes for different groups of women. A generalist overview of Australia as a safe country in which to give birth obscures a massive disparity in the safety, including the cultural appropriateness of services and the choices available to different population groups. The nation sits in the bottom half of developed countries on the children's index with twenty of forty-three developed countries outperforming Australia on the child mortality indicator, attributable in part to the number of indigenous children dying before the age of five (Save the Children, 2010). Research identifies that aspects of the gender equity framework required to reduce these disparities relate to public health policy and funding frameworks that can address important social determinants of health, including equitable access to housing, income, employment, secure food supply and culturally safe health services that meet the needs of specific groups (Kildea, Kruske et al., 2010). All women in Australia require universal access to safe, satisfying, sustainable maternal and child health services that deliver quality outcomes. This must encompass strategies that address social determinants of health: gender, power, poverty, education, culture, discrimination and structural inequalities. However, assumptions that complex issues of gender can be reduced to homogenous categories or static indices that provide accurate measures in relation to equity for diverse groups of women is flawed. Gender equity issues must be examined in terms of their overall effects on women, but can only be fully understood in relation to a specific woman and the context of her life.

Having a baby in Australia

The realities of having a baby in Australia varies considerably depending upon geographical location, education, income and health insurance status (Laws, Li and Sullivan, 2010), in addition to social and cultural influences. For two decades the Women's Movement and birth advocacy groups have demanded greater choice, continuity and control in relation to pregnancy and birth services and this

has been reflected in a plethora of state, territory and national inquiries, reports, recommendations and reviews (NHMRC, 1996; NHMRC, 1998; Senate Community Affairs Reference Committee, 1999; Reibel, Vernon et al., 2002:13). These extend from the 1989 Alternative Birthing Services Program (OSW, 1993) through to the recent National Review of Maternity Services in 2009 (DOHA, 2009), including two senate inquiries into government legislation extending Medicare maternity service options for women undertaking care with 'eligible' midwives' (Senate Community Affairs Reference Committee, August 2009; February, 2010), enacted into law in March 2010. A national rally at parliament house in Canberra in September 2009 was attended by approximately 4000 women and families from around the nation, many from regional towns and rural areas. This action was followed by 15 concurrent rallies in Australian capital cities and regional centres in late February 2010 (Our Bodies, Our Babies, Our Right to Decide, 2010). These lobbying efforts, which extended to running independent political candidates in marginal electorates at the 2010 federal election were direct responses to the threat to women's civil liberties to exercise decision making related to place of birth, in this case home birth. At that time government reform initiatives in national health practitioner regulation mandating insurance requirements jeopardised, in fact may have outlawed women's access to skilled midwifery care in the home environment for birth (Senate Committee Report, 2009: 36). Currently a two year waiver on these requirements exists until July 2012, after which time women's right to choice of birthplace will again be threatened if issues are not systemically addressed.

Distortions in Australian maternity services and tensions in service paradigms

This paper asserts there is distortion in supply, access and equity to pregnancy and childbirth services in Australia for different communities and groups of women. Issues of cultural safety and service access, including funding and geographical proximity, are not confined to Aboriginal and Torres Strait Islander women. Widespread centralization of services to metropolitan areas has seen 130 rural maternity units close since 1995, yet 30% of childbearing women reside in rural communities (RDAA, 2007). Unsurprisingly, outcomes for women and babies in these communities are poorer overall, ranging from reduced life expectancy, lower birth weights, increased preterm birth and higher rates of fetal and neonatal death (RHWA, 2007; RDAA, 2007; Kildea, Kruske et al., 2010). Disadvantage for rural and remote women is exacerbated by reduced access to maternity care and services closure (AIHW, 2008). Increasing numbers of women and children from culturally and linguistically diverse backgrounds, including those who have entered the country under refugee status also require access to public health services. This can be contrasted with the growing trend in many metropolitan private hospitals to outsource postnatal stay to luxury metropolitan hotels, extending private sector profit margins by removing women from expensive private hospital beds (Labi, 2008). Demographically, private facilities serve healthy, educated, affluent groups and are heavily subsidized by Australian taxpayers (Segal, 2004).

These contrasting realities indicate significant service tensions in Australia. Whilst indiscriminate intervention in childbirth is costly in consuming scarce resources (Quinlivan, 2004; Russell, 2008), surgical birth via abdominal extraction also imposes significant ongoing health risks for mother and baby encompassing infection, fertility, stillbirth and future childbearing (Lydon – Rochelle, Holt and Martin, 2000; Lydon – Rochelle, Holt and Easterling, 2001a; 2001b; 2001c; Victora and Barros, 2006; Tracy, Sullivan and Tracy, 2007b). These complications are now increasing in Australia. Studies that stratify for risk status validate medical intervention rates in childbearing women with healthy

pregnancies are lowest in those receiving care through the public sector (Roberts, Tracy and Peat, 2000; Shorten and Shorten, 2004). Whilst services, practices and outcomes vary across states, territories and individual facilities and providers (Robson, Laws and Sullivan, 2009; AIHW AMOSS, 2010), women with complex pregnancies are more likely to have care provided through tertiary sector public hospitals where access to comprehensive multidisciplinary services and specialized health personnel is available for woman and baby. These analyses based on National Datasets have been available for the past decade.

Equity of access and outcomes disparity

The 2010 review of Indigenous Women's Health demonstrates the maternal mortality ratio for indigenous woman is three times higher than for non-indigenous woman. In 2008 indigenous women had more babies and had them at younger ages. Twenty percent giving birth were teenagers, compared with only 4% of non-indigenous women (Burns, Maling and Thomson, 2010: 5). Perinatal mortality rates of indigenous babies remains twice that for babies born to non-indigenous women (Fredericks, Adams et al., 2010: 26) and poor access to antenatal care and poor birth outcomes for infants is linked to development of chronic disease later in life (Eades, 2004). Displacement of cultural ceremonies and tradition, disruption of Grandmother's Law and policies of forced evacuation for birth is connected to breakdown of traditional values in many communities, which increase risk factors for girls and women. Kildea and Wardaguga (2009) have written about these issues in Australia for the past decade (Kildea, 1999). In New Zealand similarly poor outcomes have plagued Maori populations. Implementation of primary midwifery care and increasing access to indigenous midwives has assisted to close these disparities in Maori populations over one decade (Gulliland, Tracy and Thorogood, 2010). Increasing access to culturally safe services with community based primary maternity services is an aspect of the gender equity framework that will reduce risk and improve outcomes for indigenous mothers and babies (Stamp, Champion et al., 2008). Disparity in outcomes between different groups of women is not inevitable and is modifiable when a more appropriate model and system of care is applied (Kildea, Kruske et al., 2010).

Internationally, skilled midwifery care optimizes outcomes

International evidence demonstrates that women with healthy pregnancies receiving continuity of care from known midwives are better supported, more satisfied with care, require fewer epidurals and episiotomies, have more vaginal, non-surgical births, fewer babies die under 24 weeks and fewer babies are born underweight or need resuscitation or admission to neonatal intensive care units (Hatem, Sandall et al., 2008). Since 1996 the World Health Organization has recognized the importance of providing skilled attendants in normal birth care to improve both mortality and morbidity for women and infants in pursuing safe motherhood (WHO, 1996: 6).

In 2010 less than 5% of Australian families can access funded, indemnified lead midwifery care in either the public or private sectors (Reibel, Vernon et al., 2002; DOHA, 2008: 10; DOHA, 2009: 15), despite evidence that midwifery is an effective public health strategy to address widespread health inequalities in different groups (Barclay, 2008; Biro, 2011: 19). Midwifery workforce and expansion of access to public models of midwifery care was identified as a priority policy, funding and health workforce issue by Barclay, Brodie et al., in 2003 in the Australian Midwifery Action Project. Whilst the Maternity Services Review acknowledges inequalities in both access to services and outcomes for individuals and population subgroups related to "socioeconomic status, risk factors and existing

service arrangements”, these were “not part of its detailed considerations”, (DOHA, 2009: 22). Addressing social determinants of health, including socioeconomic status, risk factors and the structural and funding barriers that confine women’s agency and access to engage with midwifery primary health care options in mainstream public health services is an essential part of addressing the gender equity framework. Increasing access for marginalised groups, vulnerable and disadvantaged women would seem obvious. Despite policy rhetoric (NHMRC, 2010) these areas remain strongly contested by competing professional interests in the implementation of current maternity reform processes (Newman and Hood, 2009a; Barclay and Tracy, 2010).

Maternity reform in Australia – gender equity

Gender equity issues in reproductive health are critical in implementing maternity reform. Government has recognized some of the deficits and is promoting policy, structural and workforce reform that attempts to expand service options. The stated agenda is to improve choice and access, provided as close to women’s homes as possible. This encompasses a role for midwives involving collaborative team work with other health professionals (DOHA, 2009a; NHMRC, 2010). However, the structural capacity of reforms to address deep disparity through further expansion of fee for service models is questionable and as yet untested. Assuming fee for service midwifery options constitute an adequate policy response in expanding access and equity to primary health services for disadvantaged women, or assuming that they are an advance over fee for service medical options constitutes an oversimplification of diverse and complex individual and population health needs. Other significant challenges in achieving gender equity through these reforms is the intersection and synergies perpetuated by confining pregnancy and birth within ‘risk assessment’ frameworks that do not serve the interests of individual women, nor currently disenfranchised groups. These encompass complex social determinants of health, including marginalisation, financial disadvantage, geographic discrimination and the limitations inherent in existing systems to address these deficits, or provide access to a broader range of ‘options’, for example, birth at home. This diversity divides women and fails to address institutional and professional power relations and intensifying biomedical service paradigms, including authoritative knowledge claims over disparate groups (Jordan, 1997; Bryant, Porter et al., 2007; Smith, Plaat and Fisk, 2008; Newman and Hancock, 2009b; Campo, 2010; Reiger, 2011). These unintended consequences operate to effectively service and maintain the big business interests of the Birth Industry in Australia.

Political economy of childbirth services supply in Australia

This paper claims that the political economy of maternity services supply is stifled by entrenched systemic interests that maintain policy and structural influence well beyond the lifecycle of successive governments. These interests shape relationships of power, prosperity, equality and sustainability in health, including current maternal and infant outcomes. Medical monopoly in relation to services supply has been supported by policy, legislation, funding structures and organization of the midwifery workforce. This includes utilization of a predominantly female workforce as a labour source to service institutional and biomedical interests in the market. Whether the current maternity reform agenda constitutes an adequate policy response to these interests or to women’s interests remains questionable. Examples of both policy and structural funding arrangements giving almost unlimited financial benefits to obstetricians is plentiful (Abbott, 2008; Van Gool, Savage et al., 2009b). This includes evidence that exploitation of systemic financial

advantage is intended (Noble, 2004) and practiced by some providers (Quinlivan, 2004: 26; Russell, 2008a; 2008b: 1-3; Dunlevy, 2009; Weaver and Labi, 2010). Analysis demonstrates examples practised in recent times (Russell, 2008). Between the years 2003 – 2004 and 2007 – 2008 the amount of Medicare Benefits Schedule (MBS) funding for obstetric services increased from \$77 Million to \$211 Million. Of the \$134 Million increase over 4 years \$109 Million was due to a single MBS Item 16590 for ‘Planning and Management of Pregnancy’ (Benoit, Zadoroznyj et al., 2010: 478). Of this 97% was claimed for services provided by obstetricians in private practice, resulting in a 285% increase in the earnings of private specialist medical providers (Tracy, 2008). Another example is over servicing claimed for the “Complex Birth Payment”, a Medicare item introduced by the former Coalition (Abbott, 2008). For 2007 this consumed \$98.6 Million, around a third of the total Extended Medicare Safety Net (EMSN) money allocated for whole of health. Introduced in 2004 with a suite of policies known as Medicare Plus, EMSN was designed to provide a ‘safety net’ for gap fees that would limit consumers ‘out of pocket’ expenditure for catastrophic medical expenses (Van Gool, Savage et al., 2009b). Within three years privatized obstetric services accounted for the single largest category of safety net payment (Benoit, Zadoroznyj et al., 2010: 478). Exploitation of these financial incentives was addressed under revisions to the Medicare Schedule in 2009. However, it remains uncertain whether expansion of privatized models and extension of Medicare rebates to midwives will enhance ‘choice’, or result in greater fragmentation of services for women, as providers and institutions ‘cherry pick’ aspects of care to maximise commercial funding advantages. Policy analysts and economists have long advised caution in relation to unpredictable consequences in implementing partial funding reforms in health (McAuley and Menadue, 2007; Segal, 2008), providing examples where these can have effects significantly different to that intended. Arguably this is the case in relation to Medicare Plus initiatives, where analysis of safety net payments indicates both socioeconomic and regional inequity (Benoit, Zadoroznyj et al., 2010: 478). In the absence of strong population health evidence that privatized options deliver equity, access and improved outcomes for vulnerable and marginalized populations, the likelihood of further fragmentation and distortion in maternal and infant health care services is high. This may serve market interests, but evidence demonstrates that it will not serve the interests of women, babies or health.

Use of risk as authoritative knowledge claim: Choice, Continuity and Control, or Coercion, Conformity and Compliance?

The use of authoritative knowledge and its relationship to childbirth practice has been comprehensively described (Jordan, 1993; 1997). Authoritative knowledge is not absolute nor necessarily evidence based, but it is influential, selective and powerfully manipulated to define and drive hegemonic western medical interests. These skilfully utilize the tools of science and evidence to legitimize claims (Enkin, Keirse et al., 2000). Risk in pregnancy and childbirth is skilfully applied as an authoritative knowledge claim to maintain the status quo of hierarchical relationships in biomedical services delivery (Davis-Floyd and Sargent, 1997; Skinner, 2010). Institutionalized views of risk management and safety aimed at eliminating and minimizing risk through processes of clinical governance and assessment have to date constrained women’s access to primary care midwifery services close to their homes, despite scientific evidence and advocacy to the contrary (WHO, 1996; WHO, 2005; Hatem, Sandall et al., 2010). Risk paradigms frequently negate women’s own definitions and requirements for cultural safety, known attendants and self determination. Rather than choice, continuity and control ‘for women’, what results is coercion, conformity and compliance ‘of women’

through assertion of knowledge claims and risk management frameworks that label and define a woman and her pregnancy. This includes both professional and social controls and sanctions. Culturally, notions of risk and safety that exclude women's own social and individual definitions and requirements for self determination in relation to risk and safety in childbearing and childrearing are meaningless. Alienation is a result of violating cultural safety in childbirth and is non-discriminating in its harmful effects cross culturally (Kitzinger, 2006). This is not confined to physical morbidity (Victora and Barros, 2006; Tracy, Wang et al., 2007a; Tracy, Sullivan and Tracy, 2007b; Cardwell, Stene et al., 2008) but is associated with long term psychological and mental health morbidities such as post traumatic stress disorder, childbirth fear and depression which significantly impact short and longer term mother, infant and family relationships (Creedy, Shochet and Horsfall, 2000; Buist, Austin et al., 2008; Newman, 2008b; Fenwick, Gamble et al., 2009).

It is asserted that systemic partnering of risk definition, assessment and management within mainstream clinical governance and clinical risk paradigms constitutes a convenient arrangement in which notions of 'birth as risky business' aligns neatly to support the twin agendas of privatized health and big business, not the agendas or interests of individual women or marginalized groups. This comprises a fundamental challenge to promoting safety, quality and gender equity in relation to maternal and child health. Forced evacuation of indigenous women from country lies at one end of this continuum (Kildea and Wardaguga, 2009) and 'do it yourself' home birth, or the 'free birth' movement lies at the other (Newman, 2008c; Dahlen, Jackson and Stevens, 2011). In contrast is the social model of birth which recognizes that safety is not an absolute concept, but part of a bigger picture encompassing multi-dimensional aspects of health and well being.

Childbearing: Conscious agency for an unconscious age

How individuals and groups exercise agency in childbirth says much about having a baby in Australia. This paper proposes that it is not systems that need to risk manage women, but rather women who need to adopt a proactive approach in moderating the current health systems capacity to safely and humanely meet their needs for achieving safe, satisfying pregnancy and childbirth care. Thirty years ago Illich described how institutionalized health care can have the opposite effects of its objective, reducing the beneficial effects of professionally delivered services by removing responsibility from citizens for their own care (Illich, 1975). Rising rates of surgical intervention in childbirth (Kildea, Pollock and Barclay, 2008; Smith, Plaat and Fisk, 2008; Newman and Hancock, 2009b) provides evidence to suggest the effects of both clinician and professionally initiated iatrogenesis and social and cultural iatrogenesis in childbirth in Australia has burgeoned over the past thirty years (Hamer, 2007; De Costa, 2008; Newman, 2008c; Reiger, 2011). Additionally, significant inequity amongst individual women and groups of women in relation to culturally safe services and primary maternity health access exists (Benoit, Zadoroznyj et al., 2010; Kildea, Kruske et al., 2010). Inequity encompasses child bearing outcomes as well as inequities in the extent to which many disadvantaged and marginalised women in particular, have the power and resources to apply individual agency to decisions relating to their reproductive health when they engage with the entrenched structural interests of 'risky business' and 'big business'.

Issues of gender equity are further critically informed by the writings of Saul (1992; 1997). His conceptualisation of the West as an 'unconscious civilisation' preoccupied with the application of rational solutions, management, expertise and professionalism across all aspects of our social lives is

deeply troubling. Similarly is the observation that the emergence of professionalism paralleling the rise of individualism over the last two centuries has not resulted in greater individual autonomy and self determination after the humanist tradition as was once hoped, but rather increased isolation and alienation (Saul, 1997: 34). This perspective, supported by the application of critical systems thinking (Ulrich, 2000: 256) can provide new insights into modern childbirth and in examining mainstream Australian maternity services (Donnellan – Fernandez, Newman et al., 2008). Both Saul and Ulrich provide frameworks from which to critique neo-conservative and market force arguments currently prevalent in maternity and health reform. The analogy of contemporary Western societies as ‘directionless machines run by process minded experts’ (Saul, 1992; 2010) focused on promoting self interest rather than public good, whilst unpalatable has an antidote. Saul and Ulrich’s antidote is to restore the legitimacy and agency of the individual as a citizen in a democracy. Exercising conscious individual and collective public agency can act as an effective counter to the rational application of technological power, specialized knowledge and structures utilised to exploit the broader citizenry. By cultivating their own and others consciousness citizens will ensure that the gender equity issues required to improve maternity services in Australia are addressed.

Conclusion

This paper has examined the business of having a baby in Australia. It has focused on the structural and cultural constructs of childbearing as ‘women’s business’, risky business ‘and ‘big business’ to demonstrate a series of complex relationships. Further, it emphasizes the importance of considering gender equity issues and social determinants of health when comparing disparate service access and outcomes for individual women and groups of women and their babies in contemporary Australian society. Choice rhetoric and the current maternity reform agenda notwithstanding, it concludes that if ‘having a baby in Australia’ is to improve then it is women themselves who must individually and collectively take up the challenge to create a ‘conscious’ childbearing culture. They will do this by accepting the legitimacy of their role and agency as participating citizens in a democracy where the health and status of all women and children is valued.

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Roslyn Donnellan –Fernandez is Women's and Children's Hospital Foundation Midwifery Fellow undertaking a PhD through Flinders University, South Australia. Her research focus is maternity reform, health funding and systems integration to improve public maternity services access and equity.