

The health care system as a social determinant of health: qualitative insights from South Australian maternity consumers

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Abstract

Health systems and policies are important determinants of health because they influence the type and quality of health care available to a population. This study included semi-structured qualitative interviews and a questionnaire to collect demographic data and household details for a purposeful sample of 38 mothers and 24 fathers from four socioeconomic areas of metropolitan South Australia who had at least one child aged between 1 and 6 years of age.

The participants reported that birth experiences within the predominantly medicalised maternity system were at odds with the expectations of a significant proportion of contemporary consumers that maternity care will leave them not only with a healthy mother and baby, but also with no undue adverse impacts on their physical, mental and relationship health. There appears to be no formal mechanism in place for regular consumer feedback of experiences into system and service planning.

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HEALTH SYSTEM ORGANISATION is a social determinant of health.¹ Health professionals and managers influence health outcomes through the services they make available and their appropriateness to consumer expectations and needs. However, health policies and systems are shaped by health professionals' assumptions about what

What is known about the topic?

Much has been written in the sociological and women's health literature about consumers' concern over the increasing medicalisation of maternity care in Western societies at the expense of the broader physical, emotional and social needs of birthing women and men. These concerns do not appear to be reflected in the public health literature or in efforts to mainstream models of maternity care that focus more on health promotion.

What does this paper add?

This article shows that women and men from a range of social backgrounds in South Australia who have at least one child see the dominant models of maternity care as contributing to negative impacts on their health in physical, emotional and social terms.

What are the implications for practitioners?

Those designing and managing health systems should not assume that birth experiences are benign and should consider the immediate and longer term public health impacts of intrapartum and postnatal care, alongside the impacts of antenatal care.

health is and what outcomes should be achieved, and these can differ substantially from consumer views.² Australian health departments are increasingly acknowledging the need for "appropriate" care, and reflect this in policy and service development in the rhetoric of "community participation" and "stakeholder consultation".³ Nevertheless, health outcomes from contact with a health system can be positive (eg, an enhanced physical or mental state) or negative (eg, injury).⁴ In Australia, maternity care holds the potential to affect population health, with almost 90% of Australians becoming parents and over 0.25 million women giving birth each year.⁵⁻⁶

Australian health services are still largely based on a medical model of health,⁷ and Australian

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maternity care is predominantly based on a medical and fragmented view of pregnancy, birth and parenthood, rather than a social and holistic view. Under the medical view birth is a “difficult” process from which mothers and babies need to be “rescued”, rather than a natural physiological and social process which may occasionally require medical assistance.⁸ However, over-medicalised care is increasingly out of line with consumer expectations,⁹⁻¹¹ and according to the World Health Organization, “overmedicalized care can needlessly damage the health of both mothers and babies” and “services are often not responsive enough; complaints of unhelpful and rude health personnel, unexpected and unfair costs, unfriendly opening hours and the lack of involvement of male partners are not uncommon”.¹² Increasing medicalisation, reflected in high and rising rates of obstetric intervention, can also have long-term adverse effects on mothers and babies.¹³⁻¹⁴ Maternity care planners need to acknowledge that opportunities for health result as much from the institution as the individual, that expectations driven by wider social change reflect what might be termed a “Maternity Consumer Transition”, and that a mismatch between these contributes to adverse health outcomes for mothers, fathers and babies.

This article discusses the implications for maternity care of social change associated with postmodern values and women’s education, and provides insights from South Australian parents’ experiences of maternity care, considering the implications for maternity care planning.

A maternity consumer transition

The twentieth century saw wide-ranging social change in developed countries, from traditional to postmodern thinking and lifestyles.¹⁵ This was reflected in a shift from group-directed goals to individual-directed goals, bringing a focus onto higher-order needs of self-fulfilment, personal freedom, quality of life, and increased questioning of traditional institutions and authority.¹⁶⁻¹⁷ The likelihood of postmodern values being adopted is increased by education because this

encourages increased receptivity to new ideas and the questioning of social norms.^{15,18} The proportion of Australian women with higher education has risen substantially, from 10% in 1990 to 25% in 2000.¹⁹ Since the 1970s, European and US health consumers have also increasingly asserted claims to be regarded as experts on their own health and to be actively involved in their health care decision making.²⁰ Thus, it is suggested that an increasing proportion of Australians, especially women, are likely to be applying postmodern values to their reproductive life.

In relation to reproduction, postmodern values are associated with the increased expectations of the right to autonomy, self-actualisation, achievement through personal endeavour, and freedom from social control.²¹ These are evident in the United Nations statement that women’s basic human rights include the right to “have control over and decide freely ... on all matters related to their sexuality, including sexual and reproductive health”.²² Control over one’s life is also essential for good health.²³ These rights might be expressed through women expecting greater input into decisions about their maternity care, expecting birth to leave them not only with a healthy baby but also with an acceptable quality of physical and mental health, and increasingly questioning traditional models of care. However, such expectations are often unmet in Western countries, where many experience birth as a highly medicalised, institutionalised and depersonalised event associated with feelings of disempowerment, where the institution takes control of the body, and the consumer–practitioner relationship is often one of domination and subordination.²⁴⁻²⁵ It is possible that a maternity consumer transition has occurred in Australia, resulting in a mismatch between the traditional care provided and that which many consumers would like.

Methods

Sample

This article reports in-depth interview data from 38 mothers and 24 fathers in Adelaide, the capital city of South Australia, conducted between March

2003 and February 2004 within the Adelaide Fertility and Family Size Survey — a broad study of influences of family size.²⁶ Participant selection was not based on birth experiences but on area of residence and family size. Parents with at least one child aged one to six years were in scope, on the expectation that completing or expanding their family size was likely to be a current or recent consideration. To explore influences across family sizes, recruitment was conducted so that about 25% of the 39 families recruited each had one, two, three, and four or more children. Respondents were not representative in the positivist sense because the state's birth registration data were not accessible as a sampling frame. Hence, the study could not select from all women who gave birth one to six years beforehand. Qualitative methods were used to obtain a sample with child ages and family sizes meeting the desired criteria. Maximum variation sampling²⁷ helped recruit parents usually resident in four different socioeconomic areas (based on Australian Bureau of Statistics data).²⁸ Parents were approached via public kindergartens and snowballing techniques within these areas, also using some purposeful sampling so that other characteristics potentially influencing family size could be selected, such as parents' work status (working/non-working) and relationship status (couple/single parent households).²⁹

A comparison with the Adelaide population³⁰⁻³² showed that study parents were representative of the proportion in a first marriage (62% compared with 64% in the general population), with employment (52% compared with 58% of couples with children under 15) and without employment (13% compared with 20%), and the proportion of mothers in the workforce or studying (54% compared with 52% of all mothers with children aged 0 to 4 years). Specific birthplace or ethnic groups were not targeted, but mothers were representative of all South Australian mothers giving birth in the main interviewing year, apart from slightly under-representing Asian-born mothers. Due to the selection process including about equal numbers of families from each socioeconomic area, higher-educated par-

ents were oversampled and study mothers' average age was one year higher than the state average. Study parents had diversity of education, with 63% of mothers in the highest status area having postgraduate qualifications and 60% in the lowest status area leaving school before Year 11. Fathers showed a similar but less extreme pattern. Study parents were more likely to be couples with children under 15 (87% compared with 75% in the general population), and less likely to be single mothers (13% compared with 19%) or single fathers (0 compared with 3%). Two fathers were interviewed who were separated and had partial custody of children, but they did not categorise themselves as single parents because they had girlfriends.

Data collection and analysis

Interviews lasted 30 to 150 minutes (often shorter with fathers), with a semi-structured schedule. Interviews commenced with the broad question: "So, thinking back over your life, do you think you always thought you'd have children one day, never thought you'd have any children, or didn't you really think about it?" The conversation then followed issues raised by the interviewee. Finally, the interview drew on demographic and sociological literature to probe other issues if they had not been raised (ie, impacts of conception, pregnancy, birth, early parenthood, finances, and work-family compatibility). For each question, non-leading wording was used so that the question on birth was: "So was there anything about the birth that would make you want to have, or not have, more children?" Before interview, parents completed a questionnaire providing demographic, economic and social data. Both instruments were approved by the Human Research Ethics Committee at the University of Adelaide. The author conducted and recorded all interviews and transcribed them verbatim. Interview content was categorised and codes were iteratively derived to build a set of themes. To understand pathways of influence, analysis was also conducted in the hermeneutic tradition, where transcripts are interpreted for holistic meaning rather than only being dismembered

into coding categories.³³ A qualitative or ethnographic summary with direct quotations is therefore used in this paper.³⁴⁻³⁵

Results and discussion

Mothers' experiences

Birth experiences within South Australia's maternity care system impact both positively and negatively on maternal health. Some mothers said that birth had been no issue, while others described birth as "OK" or "sort of OK" and did not elaborate further. Unless this clearly affected their desire for further children, their birth experience was not probed further. Some were unable to describe their experience due to the effects of medication at the time of the birth:

Apparently I was screaming my head off, but I don't remember so it doesn't bother me.
(Unemployed fast-food worker, age 20, mother of one child aged 1)

Others (who perhaps in the past were in greater proportions) accepted or overlooked physical and mental distress as a normal part of birth, and particularly if they strongly desired a large family:

They were long labours and things, but I can block that out enough ... I suppose I see that as a short-term issue. It was very hard at the time. (Primary teacher, age 38, mother of four children aged 1 to 7)

I was quite willing to endure whatever it took to have the number I wanted (laughs).
(Former receptionist, now home-school teacher, age 41, mother of seven children aged 1½ to 20)

However, health sociologists note that women in Western countries may not complain about negative experiences or obstetric interventions because they have come to expect this as normal within the medicalised system.^{24-25,36}

Positive experiences

Positive birth experiences were in the minority, and two mothers felt that people generally thought good births were unusual in Australia:

I do speak to a lot of women that say they had terrible births. (Professional nanny, age 30, mother of three: twins aged 2 years and a 4-year old).

[The birth] was excellent. In fact I actually enjoyed it and people think it's quite strange.
(Retail manager, age 39, mother of two children aged 3½ and 5)

Three reported their experiences positively because they had had the elective caesareans they asked for (one to avoid the pain she associated with vaginal birth, and another because she anticipated back problems after a vaginal birth, while the third gave no reason). One mother said she only wanted one child and so was not concerned about negative impacts from intervention, such as the inability to conceive or carry another pregnancy to term.

Nevertheless, good experiences could have positive multiplier effects, and appeared to relate to care meeting the postmodern expectations of self-determination, freedom from social control, and quality of life, by allowing for personal relationships and trust to develop with care providers, working *with* them to achieve good physical, mental and social outcomes alongside good clinical outcomes, and feeling that care was personalised:

The first [four births] were wonderful in New Zealand ... I had the same doctor and midwife so we had a fantastic relationship. Experiencing what I had [in Australia] was not pleasant at the birthing centre. Every visit I had a different midwife and at the birth I still had a different midwife. There's no relationship, you're just a number. (Travel office manager, age 41, mother of five children aged 4 to 11)

It was a very difficult [first] birth ... I was totally unsupported ... a different doctor each time ... [but] I'd hear these women's stories about this *wonderful* birthing ... [so] I put things in place, such as I went with an independent midwife who I felt very connected to and did share-care with a doctor that I felt very comfortable with. The second

experience was wonderful, almost healing of that first one. (*Primary teacher, age 44, mother of four children aged 2 to 11*)

Parents also talked about how their expectations differed from those of care providers and how in retrospect they could wish they had had more say:

Looking back I wish I hadn't done it that way, but it was expected that, "Your first baby, it will be difficult, you'll need your epidurals, you need all that sort of stuff that goes with it", doctors all over you and all the rest of it. I should have just said "Look, let's go with the basic stuff". (*Childcare worker, age 38, mother of three children aged 3 to 7*)

Increasing consumer involvement can challenge the values prized and reinforced by professional practice and by institutional rules and regulations, and health professionals may need education to adjust.³⁷ One South Australian mother confirmed this:

[The obstetrician was] patronising ... he would give me little glib answers and you know "He's an expert, he knows best". Then he'd come out with a comment like "Mothers, you're well educated, so you don't like control to be taken away" ... I want to do some research, to feel comfortable about having a different birth experience. (*Psychologist, age 34, mother of one child aged 1*).

Negative experiences

Just over half the mothers talked about one or more births as being generally negative experiences and, of these, half (about one quarter overall) used adjectives such as "horrific", "traumatic" or "shocking":

I was going through a bit of a hard time with the epidural so it was a very messy birth ... In fact it was a horrible birth ... When [the care provider] turned [baby with forceps] I think he ripped inside ... There was a lot of blood going everywhere. Then my placenta had to be manually removed. I had to be catheterised, that was horrible. He did a lot of stitches inside and outside. I was cut to

smithereens and my pelvic floor was destroyed. (*Company director, age 47, mother of one child aged 6*)

Many first births were perceived negatively due to the physical and emotional impacts of unwanted or painful medical interventions, "uncaring" care from staff, and treatment from many "strangers":

[No surprises with having children] except childbirth!!! (raucous laughter). Just cos I had heaps of stitches (laughs) ... and I thought I'd never have another [child] after that (laughs). The birth was really bad you know. (*Service worker, age 34, mother of two children aged 5 and 13*)

I want to have number two [child], it's just a matter of when ... The thought of going through the birth again and having a horrible experience ... turns me right off ... just scares me to death ... Forceps had to be done, so epidural had to be done, episiotomy gets done. (*Psychologist, age 34, mother of one child aged 1*)

Physical impacts beyond the birth could also affect the parental relationship:

I got a really bad haematoma bruise on the walls of my [vagina] where I must have been sitting and [it took] 6 weeks to heal and then about 3 months after that before it actually stopped being painful during sex. (*Cleaner/receptionist, age 38, mother of one child aged 2*)

Another was physically unable to mother her children for some time:

About eight weeks after [second birth] I found out I had an incisional hernia [on the caesarean scar]. The internal stitching had opened out so the bowel was sitting in the skin. So I had that repaired and three months later it happened again ... It felt like a bag of cement in your stomach. The hardest thing is you can't lift anything, so my mother came [from interstate] for about 3 months. (*Economist, age 38, mother of two children aged 2 and 3½*)

Women's self-esteem was also affected if they felt they had not been "up to the job" of giving

birth, rather than seeing their experience as potentially shaped by the care provided. Such impacts may be greater where postmodern values turn birth into an opportunity for self-actualisation:

[Husband's] mum had four natural births and his sisters had natural births, not even a Panadol ... My birth experience was such a failure compared with theirs. I overheard [the midwife] saying "Oh she's just not coping at all" so obviously compared with other women maybe I wasn't. (*Insurance manager, age 31, mother of one child aged 2*)

One mother felt that longer term mental health could also be affected by a traumatic birth:

[Friends] who have had postnatal depression ended up with long drawn out labours, caesareans, and then tried to breastfeed, and just went through hell ... extremely fatigued from trying to give birth, going through traumatic surgery ... and all of a sudden there's postnatal depression. (*Retail manager, age 39, mother of two children aged 3½ and 5*)

This potential cascading effect was experienced by another:

I had to be induced because she just didn't want to come. Then she went into fetal distress ... I had to have an emergency c-section, I never wanted to have a caesarean ... It was pretty stressful but the end result was OK and I wasn't depressed ... Then I had to go home without her, I cried without her. (*Hairdressing trainee, age 27, mother of two children aged 2 and 4, pregnant with third child*)

These findings reflect earlier Australian research which found a high level of obstetric intervention and dissatisfaction with intrapartum care being associated with women developing posttraumatic stress disorder.³⁸ Negative impacts may initially be overshadowed by the relief that labour is over but in time women may change their assessment to less positive or to "mixed" feelings when they have time to reflect.³⁹ The prevalence of very negative experiences for moth-

ers in this study (about 25%) mirrors other research where a third of Australian mothers recorded acute trauma symptoms associated with birth, and another study where one third were dissatisfied with their birth.^{38,40} The longer term unintended health consequences of birth have been little researched,⁴¹ yet physical problems can persist for months and often go undiagnosed and untreated.⁴²⁻⁴³ Furthermore, the quarter of South Australian interviewed mothers who had negative birth experiences were similar to the 25% to 30% identified in other research⁴⁴⁻⁴⁵ who were delaying or avoiding having further children because they "could not face going through birth again". Such experiences partly account for some parents completely losing confidence in "the system" and following the small but apparently now increasing trend of do-it-yourself homebirth without any professional care.⁴⁶⁻⁴⁹

Fathers' experiences

Fathers' negative birth experiences were reported in one in five families:

The birth experience was fairly traumatic. We've been a bit reassured by the fact that there was a suggestion ... that an elective caesarean might be a reasonable option [for second baby], which would take away a lot of that anxiety. (*Medical imaging specialist, age 32, father of one child aged 1*)

Two mothers also reported that their birth had adversely affected their husband's ability to bond with the baby and his contribution to parenting:

[Husband] didn't like it, thought it was foul, the childbirth ... He's vowed he'll never have any more [children] ... The birth was really bad, so perhaps that was enough to put him off completely. (*Service worker, age 34, mother of two children aged 5 and 13*)

He does *not* like talking about it at all. If I bring it up he gets upset ... He was very powerless and the baby was stuck and they tried everything. There was blood everywhere and they lost the heart beat quite a few times and at that point they assumed [baby] had died, so it was pretty traumatic

for him. (*Insurance manager, age 31, mother of one child aged 1*)

Fathers tended to talk about birth less vividly than mothers, but could still feel helpless even with low-intervention births:

The baby, that was the most exciting and important thing in my life. The worst part was the pain [wife] went through, even though it was a natural birth, and that might sound silly but ... you're sitting there going "It's all right dear ...". (*Sales representative, age 32, father of two children aged 6 and 8*)

Recent research confirms that Australian fathers' postnatal distress can negatively affect attachment to the baby,⁵⁰ and a national survey shows that Australian fathers want better preparation for how birth may physically and emotionally affect mothers, fathers, and the adults' sexual relationship.⁵¹ Many fathers also feel dissatisfied in finding their social and psychological needs not met by maternity care systems.^{11,52} Almost one in five of the South Australian fathers interviewed also said their negative birth experience had made, or would make, them delay or avoid having further children.

Babies' experiences

Babies' birth experiences indirectly affected some parents' ability to cope with parenthood, and in turn affected the parents' mental and relationship health. Four mothers who reported difficult births also said their babies had cried a lot, not slept well, and had feeding problems. One felt that her difficult labour may have had a causal effect:

My eldest girl was a very demanding baby ... maybe because of her labour? It was a really long labour for her and it was a difficult labour, you know it wasn't a nice, moving, experience ... it was a lot more intrusive. (*Childcare worker, age 38, mother of 3 children aged 3 to 7*)

Some have long suggested that a healthy pregnancy and "good" birth "set the pattern of the newborn infant and its relationship to its

mother",⁵³ and recent research confirms a link between interventionist and difficult births and anxiety in Australian children, where anxiety is defined as being fearful and having difficulties settling into novel care such as school, or leaving the mother.⁵⁴ The Longitudinal Study of Australian Children⁵⁵ includes data that could allow further investigation of how different births relate to children's later development, behaviour and health.

Implications

Although sampling limitations meant that interviewees were recruited from a small non-random sample, they were relatively representative of the general population and were not recruited in relation to their birth experiences. The interviews confirm other research showing that women (and men) prefer maternity care which allows for development of personal and mutually respectful relationships predominantly with one carer from pregnancy through to post-birth, which gives choice in how and where care is managed, allows involvement in decision making, and allows time for staff to be supportive and listen to women's concerns.^{9,11,39,56-57}

Information feedback about primary activity is an essential component of maintaining a viable system.⁵⁸ With a significant level of adverse experiences reported, and care not necessarily meeting consumer needs, it is suggested that a gap exists in the feedback loop from consumers to maternity care providers and system managers in Australia. Maternity professionals and managers need to recognise and act upon the fact that postmodern values mean consumer concerns have moved beyond basic needs, to higher order needs that also contribute positively to health. Health managers should adopt a longer term and broader view of which maternity health outcomes to measure, and understand the need for institutional adjustment in the range and quality of models of care so that policies, mainstream services and practices match contemporary consumer needs and also improve health. Managers and planners could consider what information chan-

nels could provide such feedback to estimate demand level and type for future policy and services planning. Publicly available data already exist for Victoria (the Victorian Survey of Recent Mothers) and New Zealand (Ministry of Health's national Maternity Consumer Satisfaction Survey), and collection has just commenced in South Australia.⁵⁹⁻⁶⁰

While this discussion might imply that all Australian maternity services fall short of consumer expectations, some change is apparent. In South Australia, the Women's and Children's Hospital commenced a midwifery group practice in 2004 which now covers one quarter of their maternity bookings (1000 women per year). This provides personalised care from a primary midwife working a caseload model for the antenatal, labour, birth and postnatal care for women of any risk level. Whether there is also an emphasis on non-medicalised and low-intervention care is not clear. However, evaluation shows this model provides better clinical and satisfaction outcomes than the hospital's traditional fragmented clinic model,⁶¹ and consumer demand for the new service continually outstrips supply. Nevertheless, such models are still mainly funded as *alternatives* to traditional care, so that publicly funded birth centres, midwifery group practices, homebirth services and low-intervention options such as waterbirth are not mainstreamed. Birth centre care, for example, is still only available to 3% of women Australia-wide.⁶ The system therefore restricts consumers from "voting with their feet".

Conclusion

This study confirms that birth experiences can have a profound impact, both positive and negative, on consumers' physical, mental and social health in the short and longer term. The prevalence of negative impacts also suggest that intrapartum care is not widely acknowledged as a major public health issue, in that it in turn affects the quality of the early childhood environment, which, again in turn, affects lifecourse health. Planners and managers of maternity care could consider what preventative steps could avoid the

adverse impacts discussed in this paper. A public health lens highlights the benefits of reorienting maternity services to take a more holistic and social view of maternity care so as to be more health promoting and to acknowledge the broader and longer term impacts on population health. The study supports earlier research in suggesting the need for greater mainstream provision of models which allow for more personalised care, where consumers can be active partners in decision making, and can provide feedback to care providers to support self-reflexive practice. The health institutions of yesterday no longer necessarily answer the broader health needs and expectations of today, and this study suggests that maternity care systems need to consider the broader impacts on consumers so that overall they act as a positive social determinant of health.

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Competing interests

The author declares that she has no competing interests.

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