shortages, new management structures and legislative changes to maternity services in the 1990s, until the time the hospital itself was relocated in 2004. Again, this chapter engages with national debates around childbirth services and the contributions by National Women’s staff.

The history of National Women’s Hospital cannot be divorced from the broader trends within maternity services, and focusing on this hospital illuminates those trends and the politics of maternity nationally and internationally. This volume is more than a history of one institution. It utilises the experiences of those associated with the hospital as a window into wider social issues during the second half of the twentieth century in New Zealand, and shows how doctors, nurses, midwives and consumer groups interacted to create health services for women during this period. All had a role to play, as did the government. The narrative is a complex and engaging one about the interface between science, medicine and society. The story also has a transnational component, for events in Auckland can only be understood in the context of what was happening overseas, and what happened in Auckland also contributed to that international environment.

Chapter 1

CHILD BIRTH SERVICES
IN NEW ZEALAND,
1900–1939

National Women’s Hospital was opened in 1946, at a time when most New Zealand babies were born in hospital. This had not always been the case. The twentieth century opened with New Zealand’s Liberal government firmly committed to developing childbirth services managed by midwives and not necessarily located in hospital. Yet just over three decades later, a Labour government passed legislation giving all women the right to give birth in hospital free of charge and with a doctor in attendance. The views expressed in a government inquiry into maternity services, set up by the Labour government in 1937 under Labour MP and general practitioner Dr David McMillan, were crucial to this development. This chapter investigates those views, and in particular the role of doctors and consumers in persuading the government to go down the path of hospitalised childbirth, and to found a new maternity hospital in Auckland, which became National Women’s Hospital.

A State Midwifery Service and the New Zealand Obstetrical Society

Under the Liberals who governed New Zealand from 1891 to 1912, New Zealand gained an international reputation as a ‘social laboratory’, as a consequence of its extensive social legislation. Reforms that New Zealand proudly
boasted as world firsts included granting women the vote in 1893, setting up a Department of Public Health in 1900 and passing a Nurses Registration Act in 1901. In 1904 the government passed the Midwives Registration Act with the aim of improving maternity services in New Zealand. The Act provided for the registration of midwives and for setting up maternity hospitals where they would be trained and where the wives of working men would be catered for. Seven public maternity hospitals, called St Helens after the birthplace in Lancashire of New Zealand’s Premier (Prime Minister), Richard Seddon, were established by 1921.

The Liberal government’s interest in maternity services arose directly from its preoccupation with the future strength of the nation, an anxiety that New Zealand shared with other Western nations and as part of the British Empire. A popular slogan of the early twentieth century, which New Zealand borrowed from Australia, was ‘Babies are our best immigrants’. Introducing the midwives’ Bill into the Legislative Council, Attorney-General Albert Pitt explained that the aim of registering and training midwives was to reduce infant deaths. The government considered a growing population a national asset. Discussing the Infant Life Protection Bill a few years later, one member of New Zealand’s Legislative Council declared, ‘The real reason for our solicitude . . . is that population, which is decreasing, is indispensable to national safety and national progress. We must have soldiers and workers, or our prosperity will be imperilled and our industry will decay.’

In the early twentieth century the government assumed that midwives would play an important role in future maternity services in New Zealand, which is why it wished to upgrade their training. Conjouring the image of Charles Dickens’ fictional character Sarah Gamp, Seddon declared that some midwives ‘indulge[d] a little too freely, and . . . the sooner we have legislation which will ensure competent midwives – sober and especially clean midwives – the sooner you will prevent loss of life’. Dr Duncan MacGregor, Inspector-General of Hospitals and Charitable Institutions, predicted that, ‘With the passing of the Midwives Registration Act the day of the dirty, ignorant, careless woman, who has brought death or ill health to many mothers and infants, will soon end.’ While this was not a true reflection of the competency of many midwives, 761 of whom were registered under the Act as midwives ‘of good character’, it was part of the professionalising trend of midwifery. The future midwife was to be a young, single, professional woman, just like the new nurse mandated by the 1901 Nurses Registration Act.

The St Helens hospitals, set up following the 1904 Act and under the jurisdiction of the Department of Public Health, accommodated married women whose husbands earned less than £4 a week and who would contribute towards the cost of confinement to avoid the stigma of receiving charity. The hospitals also provided a district maternity service for women who chose to have their babies at home. Midwives ran these hospitals, and there were no resident doctors; the latter were called only to deal with complications. Medical superintendents were appointed to the hospitals but they did not live on site and were summoned at the matron’s discretion.

The Health Department continued to view the St Helens hospitals and a midwifery service as central to maternity care in New Zealand well into the 1930s. The 1937 Committee of Inquiry into Maternity Services noted that in a number of countries, ‘the trend is towards a service in which the bulk of the normal midwifery is conducted by highly trained midwives’ and that ‘in such a scheme the general practitioner is excluded from all normal midwifery practice’. This was specifically the case in Holland and Scandinavia ‘where the maternity services are recognized to be of a very high order’. The report referred to a British committee representing the Ministry of Health, the British Medical Association (BMA), and the British College of Obstetricians and Gynaecologists, which recommended a national midwifery service for England and Wales, ‘based on the principle of midwife attendance in normal labour’ and which had been introduced there in 1936. The report cited the evidence of Dr Henry Jellett, formerly master of the Rotunda Hospital, Dublin, who had immigrated to New Zealand in 1920 and was consultant obstetrician to the Department of Health from 1924 to 1931. In Jellett’s view, for normal births, ‘it is a mistake to bring in the complication of the medical man who has to attend all kinds of disease, statistics and history having proved over a period of years in other countries, and also at Home, that these cases can be attended more satisfactorily by midwives’.

Generally, however, the 1937 committee did not favour the British model of a midwifery-based service. While two of its six members, Dr Sylvia Chapman, medical superintendent of Wellington’s St Helens Hospital, and Dr Tom Paget, the Health Department’s inspector of hospitals, advocated a midwifery service, the report endorsed doctor attendance for all births in hospital.

Doctors had lobbied against a midwifery system for a decade prior to this inquiry. In 1927 a group of doctors formed the New Zealand Obstetrical Society (NZOS) to represent the interests of doctors who practised obstetrics.
At its 1929 meeting, members resolved to draft a maternity services plan since ‘Dr Jellett had recently published his proposals for the future midwifery service of this Dominion, which proposals eliminate the doctors from attending cases of normal confinement.’

In the midst of the economic depression in 1933, the Obstetrical Society noted that Paget had recently ordered the various hospital boards which ran New Zealand’s public hospitals to make provision for indigent maternity cases within their areas, based on a scheme that was ‘an exact parallel of the English midwife service’. The society was concerned that this policy, perhaps introduced as an emergency measure, might become the ‘thin edge of a permanent wedge’. It resolved to reaffirm the principle that ‘the ideal obstetrical service for every confinement in this Dominion is a doctor and a midwife or a doctor and a maternity nurse attending’. The following year the society repeated this resolution in the light of a perceived trend for more women to be confined by midwives alone, declaring their belief that ‘for reasons of safety to mother and infant, reasonable pain relief, and elimination of future pelvic weaknesses’, a doctor and a trained nurse should be present at every delivery.

Dr Bernard Dawson, professor of obstetrics and gynaecology at the Otago Medical School, warned his colleagues that ‘a small cloud can herald a thunderstorm’. With an eye to Britain, where he said the percentage of midwife deliveries had increased from 58 to 75 over the previous decade, he averred, ‘It is usual for methods adopted by England to be advocated sooner or later in her Dominions’, adding that the midwife system of maternity service already had advocates in New Zealand. He advised the medical profession to devise a scheme that included midwives ‘rather than be left inarticulate and bereft when some Bill for Maternity Services detrimental to our interests becomes an enactment’. Dawson clearly saw midwives as competitors.

Dr Thomas Corkill, at that time president of the NZOS, not surprisingly was also outspoken about doctors’ involvement in births. Graduating in medicine at Edinburgh in 1915 (where he also completed his MD in 1920), Corkill practised obstetrics in Wellington from 1921. He became a member of the (British) College of Obstetricians and Gynaecologists in 1934, and a fellow in 1937. In a 1933 article in the New Zealand Medical Journal (NZMJ) he addressed the argument put forward by Jellett, among others, that maternal mortality was much lower for midwife-conducted births than doctor-attended cases. He noted that textbooks often warned against a doctor’s presence during labour, as this was ‘more likely than anything else to promote weariness and tempt interference’ which were detrimental to the woman’s welfare. Yet he argued that one advantage of the doctor’s presence at the time of delivery was ‘much more satisfactory anaesthesia’. His main argument in favour of doctors attending normal births, however, was that only by such experience could they gain a sense of the abnormal. In his view, doctors should be involved in normal births to enhance their knowledge of obstetrics for the greater good of all. Corkill was one of the members of the 1937 Committee of Inquiry into Maternity Services.

The 1937 inquiry was not swayed by medical argument alone, however. Three members of the committee of seven represented women’s organisations, Mrs Amy Hutchinson, Mrs Agnes Kent-Johnston and Mrs Janet Fraser. Whilst the latter was the wife of the Minister of Health and later Prime Minister Peter Fraser, she was also active in women’s issues in her own right. All three were explicit about their preference for hospital births, as were some of the women who came before the committee as witnesses. For instance, when Dr Paget asked Mrs McGuire of the Onehunga Labour Party whether she preferred a maternity hospital or a nurse service in the home, she replied, ‘We think a hospital is the better.

Hospital Births and Pain Relief: Women’s Demands

In the early twentieth century most women delivered their babies at home. In 1920 fewer than 35 per cent of births occurred in hospital (defined as an institution with two or more beds). At that time the Health Department’s Director of Nursing, Hester Maclean, supported home births, believing that the ‘large majority’ of births could take place at home provided conditions were ‘reasonably comfortable’. Yet a decade later 57 per cent of New Zealand births occurred in hospital. In 1936 Dawson maintained that the fact that over 60 per cent of New Zealand women gave birth in hospital proved that the majority preferred hospitals, ‘even in perfectly normal confinements’. The 1937 Committee of Inquiry contrasted New Zealand with England and Wales, where only 15 to 25 per cent of births took place in hospital compared to 81.75 in New Zealand. This was the case despite the fact that in New Zealand most women had to pay for the privilege.

New Zealand’s health system prior to the 1930s was a mixture of private and public hospitals. Public hospitals, run by elected hospital boards, were funded by a combination of government subsidies, voluntary donations and patients’ fees, with those patients who could pay being required to do so.
In 1930, with a population of under 1.5 million and about 27,000 births per annum, New Zealand had well over 1,500 maternity beds available in institutions. This included 76 public hospitals containing maternity wards or maternity annexes, providing 506 maternity beds. New Zealand also had 274 private maternity hospitals; most of these were small, with an average of fewer than four beds per institution (and 873 beds in total). There were also unregistered private one-bed institutions run by midwives; Auckland alone had at least 25 of these in the 1930s. Finally, the St Helens hospitals, with their heavily subsidised fees, accounted for an additional 121 beds. Still it was not enough. By the 1930s New Zealand women almost took it for granted that the best services for childbirth were hospital-based. New Zealand’s National Council of Women (NCW), which had been set up in 1896, had long kept a watching brief over women’s affairs. When the Auckland branch of the NCW set up a sub-committee to look into maternity services in 1936, they called it ‘The Committee on Maternity Hospital Services in New Zealand’.

This was partly a reflection of the changing public image of hospitals generally. In the nineteenth century, hospitals had been regarded as places of last resort, where someone would go when they could not be cared for at home. The advances in scientific medicine changed the public image of hospitals; gradually the public came to accept them as respectable places of curative medicine. Women in childbirth wanted all the advantages that modern science could give them. Historian Judith Leavitt noted of America that ‘women in alliance with obstetrical specialists decided to move childbirth to the hospital’, and explained that ‘they made this decision because they believed in medical science’. Canadian historian Wendy Mitchinson also argued that Canadians had developed faith in science, and that, ‘Much in a hospital setting gave the patient the feeling that everything that modern medical science could offer was available to her.’ Jane Lewis concluded from her research into the history of maternity in Britain that women went into hospital because of fear of the pain and the health consequences of childbirth.

In New Zealand too childbirth was feared in the early twentieth century. In her history of childbirth in nineteenth-century New Zealand, Alison Clarke explained that women were very aware of their vulnerability as they prepared to give birth. She noted that letters frequently included expressions of relief and gratitude following childbirth, reflecting the very real dangers women had faced. These fears were common knowledge. Premier Richard Seddon was not alone when he spoke of ‘the dark hour of maternity’, and nor was another MP who referred to ‘that great dread which is felt as the time of maternity approaches’. This apprehension was heightened after the First World War when it was announced that New Zealand had the second-highest maternal mortality rate in the Western world. Women were not reassured by a pronouncement of a Board of Health committee set up in 1921 to look into this situation that, ‘Childbirth is a normal physiological process, and to the healthy woman in healthy surroundings is attended with very small risk.’

There were reasons other than health concerns for women to prefer hospitals for childbirth. Lewis wrote of Britain, ‘A ten-day rest in hospital made sense in the context of the hard household labour performed by working-class women.’ In the American context, Leavitt considered the physical and psychological isolation of many women to be important in their decision to enter hospital; they could not find the help they needed in their own homes.

With its perennial shortage of domestic servants and the frequent absence of extended family, New Zealand shared these characteristics. Dr Emily Siedeberg McKinnon, medical superintendent of Dunedin’s St Helens Hospital, mentioned a factor counterbalancing the attraction of hospital births, however, when she told the 1937 Committee of Inquiry, ‘I do not know whether it is difficult to get [domestic] help or not, but I do know that a fair number of mothers are afraid of the infidelity of their husbands. That is a definite difficulty in persuading a woman to go into hospital, and even when they do go to hospital they are always anxious to get home again on that account. As a member of the Society for the Protection of Women and Children I have encountered many such cases.’

One of the clearly recognised drawcards of hospital births (and probably outweighing any concerns about their husbands’ infidelity) was that pain relief was more readily available in hospital than at home. Pain relief dates back to the mid-nineteenth century. First administered in 1846 by an American, Dr William T. G. Morton, it quickly spread to Europe and began to be used in childbirth as well as surgery. In 1847 Professor James Young Simpson of Edinburgh gave a birthing woman ether inhalation anaesthesia, and later tried another inhalational anaesthetic, chloroform. Shortly after, an American dentist, Horace Wells, published his work on nitrous oxide. Very soon these three general anaesthetics became widely known and were all used in childbirth. Some opposition persisted, based on the biblical injunction that ‘in sorrow thou shalt bring forth children’ and the related belief that women were meant to suffer in childbirth. Opponents of pain relief, sometimes including

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herself, also argued that anaesthesia gave doctors unchecked powers over their patients. Opposition faltered, however, after Queen Victoria had chloroform for her eighth delivery in 1853. Wealthy women, in particular, began to pressure doctors for chloroform. With regard to America, Leavitt described nineteenth-century women as more eager than their physicians to invest in pain-relieving agents such as chloroform and ether. The same was true in nineteenth-century New Zealand. In her history Alison Clarke related the story of Amy Barkas who demanded chloroform: ‘Amy was a determined woman, wealthy enough and assertive enough to find a doctor willing to do what she wanted.’

In the early twentieth century another form of pain relief was introduced in an attempt to avoid the risks related to total anaesthesia. A narcotic analgesic consisting of injections of scopolamine and morphine, dubbed ‘twilight sleep’, caused a state of semi-consciousness in the woman; it did not abolish pain but the memory of it. In America a group of women, mostly suffragettes, set up the National Twilight Sleep Association in 1914 to pressure doctors to provide this alternative to painful childbirth. They argued that the availability of analgesia was a fundamental right. As historian Donald Caton commented, ‘In articles and editorials alike American physicians were accused of rejecting Twilight Sleep because of its promotion by patients rather than medical colleagues, because of procrastination in learning about the subject, or a callous indifference to the pain of women in labor.’

‘Twilight sleep had major drawbacks. In America the campaign in its favour suffered a setback in 1915 when one of its leading advocates died in hospital whilst undergoing a twilight sleep delivery. British historian Irvine Loudon explained that twilight sleep often produced a disorientated and restless mother, unable to cooperate and extremely difficult to manage, who needed constant attention throughout labour. He noted that it was virtually abandoned in America and Britian in the 1920s, the whole affair being regarded as the ‘twilight sleep fiasco’. In New Zealand Dr Doris Gordon, whose activism in obstetrics will be discussed in the next chapter, pioneered the use of twilight sleep in childbirth, and continued to favour this method of pain relief long after it had fallen from favour in Britain. In 1937 she claimed that her private hospital in Stratford had been a ‘twilight sleep’ hospital for 20 years. She reported that the stillbirth rate was much lower than at the St Helens hospitals, a point she stressed because during 1925–30, she said, the Health Department had strongly opposed its use and had convinced the public of its dangers. She claimed that many women who had been afraid of giving birth were more willing to have children once they had experienced twilight sleep in her hospital, but she added, ‘Twilight Sleep can only be given by people who are really enthusiastic about it, and I usually spend the night in hospital when there is a case here.’ She also championed chloroform, which continued to be the predominant form of obstetric pain relief in Britain up to the Second World War, particularly for women in private hospitals.

Many women seemed to favour doctors’ involvement in childbirth because of the latter’s ability to dispense pain relief. In 1933 the Auckland branch of the NCW sent a remit to the national conference that resident medical officers should be appointed to all St Helens hospitals in the Dominion. Two months later they clarified that they meant ‘medical officers in the capacity of anaesthetists’. The secretary was instructed to find out whether St Helens’ matrons and nurses were qualified and authorised to administer chloroform, and whether they gave it ‘only in cases of extreme difficulty; also may the patients have it if they wish’. They viewed pain relief as a woman’s right. Mrs Amy Hutchinson spoke in support of the remit and read a lengthy letter from Mrs Stanley Baldwin, wife of the British Prime Minister, giving details of the management of maternity hospitals ‘at Home’.

Mrs Stanley (Lucy) Baldwin had helped set up and was vice-president of a British voluntary organisation, the National Birthday Trust Fund, founded in 1928 to improve maternity services. The organisation focused on three issues: increasing the availability of health services for poor women, improving nutrition for young children and relieving the pain of childbirth. Mrs Baldwin assumed responsibility for the fund’s efforts to increase the availability of obstetric anaesthesia. She later formed the Anaesthetic Appeal Fund, an organisation separate from, but affiliated with, the National Birthday Trust Fund.

Baldwin believed passionately that all women should be offered pain relief in labour as a fundamental right, regardless of their social status or income. She admired Finland, ‘that little progressive nation which was the first in Europe to give the franchise to women’, where she said anaesthesia in childbirth was always given. The novelist Virginia Woolf also suggested that one advantage of the political empowerment of women would be a government that provided every mother with chloroform in childbirth.

Modern women, like their male counterparts, believed in the efficacy of modern science. The National Birthday Trust Fund allied itself with the...
British College of Obstetricians and Gynaecologists, and underwrote college research projects such as that by R. J. Minnitt, a part-time obstetrician at Liverpool Maternity Hospital, who was developing a nitrous-oxide-and-air apparatus for obstetric use. The college conducted trials in 1936, concluding that nitrous oxide was safer than chloroform, and the National Birthday Trust Fund began distributing gas-and-air machines, free or at a discount, to hospitals.53

Women in New Zealand shared a similar objective to their British counterparts. To Vera Crowther, a British-born nurse and feminist who had immigrated to New Zealand in 1924 and subsequently joined the Communist Party, it was a class-based issue. She believed it unfair that women who were ill-nourished, overworked and mentally distraught with domestic and financial worries should ‘suffer depletion and exhaustion of all their human powers in childbirth’. She compared the movement to provide universal pain relief with the suffragettes’ fight to gain the vote. She wrote in 1937, ‘to gain the confidence of working mothers is to know without doubt that disinclination for children is caused [first] from fear of the actual confinement’. Accused by certain doctors of exacerbating this fear herself, she responded that those who were most frightened were the ones who had already had the experience (she herself only had one child).14

Crowther’s was not a lone voice. The New Zealand Society for the Protection of Women and Children (NZSPWC), like the NCW, had been set up in 1893 and also kept a watching brief over women’s affairs.55 In 1936 the Auckland branch summed up what appeared to be a widespread consensus among women when it sent a set of recommendations to Health Minister Peter Fraser for improved state maternity services:

This Society is anxious that every woman, married or single, rich or poor, giving birth to a child shall be provided with the utmost attention and relief from pain which science can provide. As this can only be obtained by the services of both a doctor and a nurse, the Society urges: ‘That hospital accommodation for all classes of maternity work be extended, and that in such hospitals, resident medical officers specialised in obstetrics and gynaecology, be appointed, one of whom shall be present at every delivery.’16

The report stated that the existing practice at the St Helens hospitals resulted in ‘prolonged and unnecessary suffering for the patient’.57

A 1937 report of a government inquiry into abortion that led to the subsequent inquiry into maternity services stated that several witnesses had suggested that fear of pain relief being withheld in labour was a factor in women seeking illegal abortions. The report declared, ‘an erroneous idea seems to be prevalent among certain sections of the laity that the total abolition of pain during labour is possible for every patient’.18

The NZSPWC was particularly critical of the practices at the St Helens hospitals. Its representatives reported having interviewed seven women who had given birth at Auckland’s St Helens Hospital. ‘Without exception’, they said, these women stated that only financial reasons prevented them from having a doctor present.59 One of the society’s representatives, Mrs Nellie Molesworth, explained in 1937 that she had been an inspector for the society for nine years, and had interviewed many of these women ‘of the poorer class’. She claimed to have heard ‘very distressing stories of unnecessary suffering’, because unless the case was ‘abnormal’ they had received inadequate pain relief. Most were given a ‘Murphy Inhaler’, which could be administered by midwives and consisted of a teaspoon of chloroform, but, she said, they found it ‘almost useless’, and moreover, ‘very often it is taken from the patient and they are told to do more to help themselves’. She also heard of stitches being inserted by the matron or a sister without anaesthetic. She reported that many women who had to go to St Helens because of their financial circumstances ‘dread a confinement so much that they have told me that they would rather die than face it again’.60

Janet Fraser was equally outspoken about pain relief. She reported that she had heard that mothers who went to St Helens were afraid because no anaesthetic was given there, and she was clearly not persuaded by Dr Paget’s retort that this was an impression deliberately conveyed by the medical profession.61

The NZSPWC told the 1937 Committee of Inquiry into Maternity Services that it believed that adequate relief should be given in all cases and research carried out to improve methods, declaring that, ‘painless maternity is every woman’s right’.62 Most women’s groups that addressed the inquiry agreed with the Auckland Women’s Branch of the New Zealand Labour Party, which demanded ‘complete relief from pain by the most modern methods providing there is no danger to either the mother or infant’.63

The campaign for pain relief in New Zealand differed to some extent from that in Britain. The latter focused primarily on providing safe analgesia that midwives could administer without supervision.64 By contrast New Zealand women appeared to favour doctor attendance. Mrs Kent-Johnston explained
that from a psychological point of view, a ‘woman prefers to have a doctor’. The seven women interviewed at St Helens expressed the feeling that it would give confidence to know a doctor would attend them’. One of the women went so far as to declare that ‘she had known a young woman who lost her baby “because she lost confidence”’.66 Doctors were the arbiters of medical science and therefore the best service included their involvement. Nurses agreed: the Obstetrical Branch of the New Zealand Registered Nurses Association stated that the ‘highest ideal’ was to have a doctor present and regretted that such services were not currently available.66

Women drew on professional authority to support their case. In a letter to the Minister of Health in 1936, the NZSPWC cited a 1934 report of the New Zealand Obstetrical Society which, it claimed, ‘definitely supports our resolution’ of having a doctor present at every delivery to ensure the health and safety of mother and infant and for ‘reasonable’ pain relief.67

The 1938 Social Security Act
In November 1935 the first Labour government swept into power in New Zealand, promising social security from the cradle to the grave. The commitment of the new government to social justice, and the importance it attached to building a strong population base, ensured that maternity services were high on its agenda. Founded in 1916, the New Zealand Labour Party had included ‘nationalisation of the medical services and free medical and maternity attention’ as one of its election platforms from the 1920s.68 In 1938 the government passed the Social Security Act; among its provisions was a free maternity service under which all women could give birth in hospital with a doctor in attendance.

The political goal of ‘national efficiency’ that had led to reform of childbirth services in the early twentieth century was heightened by the imminent threat of another war. The Obstetrical Society (from 1935 the New Zealand Obstetrical and Gynaecological Society, NZOGS) marshalled this argument. It had established contact with the English Population Investigation Committee in the late 1930s, and, claiming a ‘definite responsibility for arousing public opinion to heed the immediate dangers of race suicide’, it offered to assist the government to investigate the reasons for falling birth rates.69 At the close of the Second World War the society again pointed to the importance of increasing birth rates, and declared that the welfare of mothers and infants was a ‘matter of Dominion defence’.70

Women likewise took advantage of this national concern to push for the kind of maternity services they wanted. For example, Mrs Cassey, representing the Women’s Auxiliary of the Unemployed Workers’ Union, and Mrs Stewart of the Devonport Housewives’ Union, told the 1937 Committee of Inquiry into Maternity Services that, ‘If you want population then you must cater for them in the proper way’ through a state maternity service. Mrs Cassey added that as the government considered the child to be an ‘asset to the country’, it should ‘be prepared to maintain that asset and bring it into the world free’.71

The recommendations of the 1937 Committee of Inquiry led to the inclusion of a maternity benefit in the 1938 Social Security Act, effective from 1939. This benefit allowed women to give birth in hospital and stay there for fourteen days free of charge, or to access the services of maternity nurses and midwives for a home birth and for fourteen days thereafter. An ‘obstetric nurse’ could claim a benefit as a midwife (practising without a doctor in attendance) or a lower benefit as a maternity nurse (assisting a doctor), and a total of 290 obstetric nurses signed contracts to provide maternity services. Women thus had the choice of home or hospital, doctor or midwife. Over the next ten months, 22,652 women gave birth in hospital and 1854 (or 7.5 per cent of all births) at home.72 So, according to Joan Donley, the maternity benefit completed the medicalisation of childbirth.73 Or, as Doris Gordon put it, New Zealand was the first country in the British Empire to allow women in childbirth to be the ‘financial guests of the Government’.74

The argument for improving facilities to train doctors in maternity care was strengthened once the government had endorsed doctor-led maternity services and it became clear that women were taking up this option. As the NZOGS pointed out in 1945, without providing postgraduate training for doctors, the government could not purchase what the public wanted, that is, ‘a most efficient State obstetrical Service’. It argued that paying inexperienced doctors would court disaster, and that the Maternity Benefits Scheme should incorporate within its framework the establishment of an up-to-date women’s hospital located in Auckland, the most populous area of New Zealand. That hospital would train house surgeons who wished to specialise in obstetrics, provide courses for young doctors proposing to work in the Maternity Benefits Scheme and refresher courses, and assist in the training of sixth-year medical students.75