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Dear Bronwen,

Enclosed is a copy of a press release I have prepared and circulated in Auckland. Could you please circulate the same in ~~Wellington?~~ your area?.

Enclosed also are two extracts from the recently released Health Benefits Review Team report which are very encouraging.

I will forward a copy of our final set of claims after my meeting with Joan and Alison this Friday.

Kind regards and best wishes for Christmas.

Yours sincerely,

Kelly Grovehills

Kelly Grovehills

PRESS RELEASE FOLLOWING THE RELEASE OF THE MEDICAL BENEFITS REVIEW TEAM REPORT

The Domiciliary Midwives Society representing all New Zealand domiciliary midwives:

1. Applauds the thorough and honest appraisal of the current health care system in New Zealand, afforded by this report.

2. Fully supports the underlying appreciation that health spending needs to concentrate more on primary, community-based, preventitive care and away from secondary, curative health care as we have at present, or to use the analogy currently in vogue move to funding the fence at the top of the cliff and away from the ambulance at the bottom of the cliff.

3. Applauds the recognition by the review team of the unique position of the domiciliary midwife - who is at present restricted by law from practicing in her own right and who recieves a significantly lower level of income than other health professionals working in the area of normal childbirth and obstetrics. Both these factors considerably reduce the availability of the home birth option to healthy women expecting a normal childbirth who are thus forced into "medicalised" hospital birth where they become vulnerable to very expensive and unnecessary high-tech medical intervention.

4. The report also implies that the reason for the low level of payment is a reflection of the established medical profession's attitude to home birth as an "unsafe, second-best option" an attitude which flies in the face of the statistical facts, the ever increasing demand for home births and the high degree of consumer satisfaction evidenced by the formation of strong and ever growing numbers of regional home birth associations.

Specifically, the report has endorsed the home birth option and highlighted the need for a further review of the uneven pattern of maternity subsidies and further investigation into the status of the domiciliary midwife.

Such an review is already long overdue. The situation is a crisis one and the Government must now act urgently to raise the level of income to domiciliary midwives by which ever mechanism is considered most suitable, to one which fairly reflects their level of commitment, the quality of their service and their specialised training.

Home birth is an immediate and practical example of effective primary health care allowing parents to take more direct responsibility for their own health and which will prove cost-effective both in the short and long term.

The Government has voiced a commitment to the home birth option but the current level of benefit, notwithstanding the increase granted earlier this year, belies this. It must now keep faith with its commitment to keeping the options for maternity care open.

The Domiciliary Midwives Society will be presenting submissions to the Health Department immediately for an increase in the level of maternity benefit paid to them. This will be followed early next year with submissions on the future directions of midwifery training and a comprehensive code of practice that will ensure full accountability whilst seeking the necessary legislative changes to allow midwives to provide normal childbirth services in their own right.

Efficiency: the state-funded service seems to have been effective in improving dental health. One crucial question is whether success can be sustained once free care ends. While the general dental health of the population has been greatly improved, there is nevertheless a higher evidence of untreated dental problems after the age of 16. This deterioration is greatest among lower socio-economic group members. It is useful to ask to what extent this could justify an extension of the fully subsidised service, and whether it would be an efficient use of funds.

At present there is a lack of co-ordination among policies relating to children, teenagers and adults. In schools the reduced need for treatment means that dental nurses can concentrate on promotion of oral health. However, the teenage dental service is fee-based, so there is little financial incentive for dentists to be involved with health education or prevention activities —except that if patients are more aware of dental hygiene they may return in later years (as paying patients). Moreover, since the benefit must be accepted in full settlement, dentists who wish to give time to these activities with teenage patients do so at a cost to themselves. Whether a dentist can charge for preventive activity with adults will largely depend, under our present system, on the patient's willingness to pay for the service. All of these are considerations which have a bearing on the efficiency of the present system.

Provider issues: the level and system of remuneration under the dental benefit scheme has long been a source of widespread dissatisfaction amongst dentists. Payments for the delivery of dental benefit services are made according to a schedule of fees in full settlement for services rendered. Disagreements with the government over a review system and the lack of any system of arbitration have meant that these fees have become seriously eroded. They are now generally less than half of the equivalent private fee. According to dentists, the fees often do not even cover the cost of providing the service, and yet dentists are prevented by law from recovering the balance from any other source.

Any dentist who accepts a contract to provide dental benefit services does so voluntarily, and most private practitioners are contractors. It is therefore perhaps surprising that—in spite of continuing dissatisfaction—very few have chosen to terminate their contracts so far. In the long term, however, professional providers require realistic financial incentives. Unless that incentive is restored by an increase in the level of remuneration for dental benefit services, the scheme may collapse.

Domiciliary Midwifery

Although there are less then 40 midwives in the country claiming the domiciliary midwifery benefit, this is a service, and a subsidy, that has generated a lot of interest and which features in many of the submissions to us.

Home birth is an option which has always been available in New Zealand, although, in step with the rest of the world, hospital-based delivery has come to be the norm. Planned home births now represent less than one per cent of all New Zealand births. When the maternity benefit was introduced in 1939 a benefit was included to reimburse domiciliary midwives who attended the mother at home at the birth and for 14 days afterwards. The midwives sign a contract with the local district office of the Department of Health (or the area health board where one exists) but they operate as private practitioners. Any woman giving birth at home must also be under the care of a doctor (but not, by law, vice versa—she may have a midwife but must have a doctor).

Domiciliary midwives are paid on a fee-for-service schedule which was amended this year after considerable lobbying from user groups. Before the increase, it had been estimated that the average earnings of a domiciliary midwife were about half that of a hospital midwife for similar working hours and many more hours on call. The rate increased by 50 percent, so they are still lowly paid by comparison (see Appendix 1 for actual rates).

Issues: some points of general interest emerge from this discussion. Firstly, domiciliary midwives offer a service which is frowned upon by a large section of the medical community who consider home birth as an unsafe, second-best option which is best discouraged. The low rates of pay may not be entirely unrelated to this attitude.

Secondly, such a very small group of providers have little political leverage and are easily overlooked. However, there is now a vocal home birth movement that has spoken out for the midwives: the number of submissions we have received in support of them bears witness to this. The issue of home birth is associated with the increasing notice taken of patients' rights and women's health issues. The ability of pressure groups in this area to make some headway against the medical establishment demonstrates their growing influence.

Physiotherapy

Physiotherapists treat injury, disease and disability, using massage, manipulation and other means to restore or improve function and to relieve pain. There are 3973 names on the Register of Physiotherapists and 1679 physiotherapists currently in practice. Seven hundred and ninety five (47.4 percent) are in private practice and 747 (44.5 percent) are employed by hospital boards, while the remainder work in a variety of other settings, including teaching. Those in private practice usually hold a contract with the Department of Health to provide physiotherapy services and claim physiotherapy benefits on behalf of their patients (see Appendix 1 for details). The benefit may be claimed only for services given to patients referred by a medical practitioner.

The period since the introduction of ACC has seen dramatic changes in physiotherapy practice, in the number of services provided, and in the cost. Since 1974-75, physiotherapists in private practice have increased from 24 percent to 47.4 percent of the workforce, and health benefits payments for physiotherapy have increased from $1million to $2.2million, while ACC payments have increased from $0.9million to $13.3million. ACC currently accounts for about 73 percent of visits to physiotherapists.

The consequences have been serious. There is a marked difference in income levels between the public and private sectors and, as a result, hospital boards have been unable to recruit and retain staff. In November 1985 there were 107 hospital board vacancies for physiotherapists—13 percent of the staff complement. The shortage has led to the disestablishment of some services. The advent of ACC has also led to a divergence in physiotherapy practice, with short-term treatment being fostered by fee-for-service under ACC and longer-term rehabilitation and preventive work — especially for the elderly and the chronically ill—being left to the (public) hospital-based services.[24]

Here again, there are equity problems because financial access to services for those who have suffered an accident is so much easier than for those needing treatment for illness. Questions of efficiency arise because the allocation of resources to physiotherapy is not governed by considerations of value for money, but by priorities set by the third party funders.

Other Providers

Most other narrowly-targeted primary health care workers—such as podiatrists, psychologists and optometrists—receive no government subsidies. In some cases alternative public hospital services are available free (as is the case for podiatry) but such services are quite heavily restricted and probably do not compete greatly with their private counterparts.

[24] When these services are provided in a private hospital or rest home, most of the cost is met by the patient.