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# DOMICILIARY MIDWIVES' WAGE NEGOTIATIONS: ANALYSIS OF OPTIONS & SUGGESTIONS

March 1982

First, we must define ourselves. The domiciliary midwives are a minority group of registered nurses/midwives (RN,RM) under contract to the Department of Health. Officially we are classified as belonging to the 'private sector', as opposed to the majority of nurses and midwives who work for hospital boards and are known as the public sector.

As individuals we are eligible to membership in the N.Z. Nurses' Ass'n. This costs $66 p.a. The only probably advantage to be derived from this membership is the $100,000 indemity insurance against professional malpractice and negligence. The NZNA classifies itself as our "professional organisation and for nurses working in public hospitals, your negotiating body." (NZNZ Members Handbook).

If our professional organisation is not our negotiating body, who is?

The N.Z. Nurses Industrial Union of Workers represents nurses employed in the private sector; and members of the Union may also be members of the NZNA. The N.Z. Nurses Industrial Union of Workers is the negotiating body for:
- private hospital nurses;
- occupational health nurses;
- Plunket nurses;
- Nurse Maude district nurses.

The Union was formed and operates under the terms of the Industrial Relations Act of 1973.

Other negotiating bodies acceptable to NZNA are the Combined State Unions (CSU) made up of employee groups employed by the State. It is an unincorporated body which works as an extension of its members, all of whom are incorporated bodies. (See Table 1) It acts as a watch-dog in matters affecting state servants.

Table 1

| CSU Member groups | Number of members |
|---|---|
| Assn of N.Z. University Library [illegible] | 288 |
| Assn of Teachers in Technical Institutes | 1864 |
| Dockyard Unions | 385 |
| National Union of Railwaymen | 11400 |
| N.Z. Anns of Occupational Therapists | 272 |
| N.Z. Dietetic Assn (Inc) | 134 |
| N.Z. Educational Institute | 17988 |
| N.Z. Free Kindergarten Teachers Assn | 980 |
| N.Z. Hospital Engineers Assn (Inc) | 141 |
| N.Z. Insitiute of Health Administrators | 40 |
| N.Z. Inst of Medical Lab Technology | 1006 |
| N.Z. Locomotive Engineers Assn | 1975 |
| N.Z. Nurses' Assn (Inc) | 11386 |
| N.Z. Post Primary Teachers Assn | 11849 |
| N.Z. Public Service Assn | 68124 |
| N.Z. Railway Officers Institute | 4580 |
| N.Z. Railway Tradesmen's Assn | 2325 |
| N.Z. Society of Physiotherapists | 298 |
| N.Z. Society of Radiographers | 260 |
| N.Z. Teachers College Assn | 433 |
| N.Z. Workers Union | 8150 |
| Post Office Union | 37500 |
| Technical Institutes Allied Staff Assn | 420 |
| Teacher Trainees Assn of N.Z. | 5300 |
| Total | 187093 |

(From NZNJ, October 1981

The Executive Committee of CSU is made up of representatives of the areas within the State service. Virtually all its decisions are reached by consensus. The CSU negotiates changes to allowances and conditions which effect more than one service. Items which affect one service only are termed single service and are dealt with by the individual organisation - in our case the NZNA. That puts us back to sqaure one!

Basically, the increases obtained for State servants depends greatly on what the private sector unions (FOL) have been able to achieve for their members. The General Wage Order of 5% which became effective 11 June 81 resulted from a claim lodged by the FOL & CSU. This 5% increase determined by the Arbitration Court applied to all nurses' salary rates and allowances - except, of course those of domiciliary midwives!

A superficial survey would indicate that theN.Z. Nurses Industrial Union would appear to be the logical body with which we should legally affiliate. However, Shona Carey, Executive Director of NZNA is also National ecretary of the Nurses Union. The NZNA industrial officer is responsible to this Executive Director for the preparation and negotiation of all salary claims. Shona Carey is also the Hospital Services Representative on the Executive of CSU which would render that body suspect in its ability to operate in the best interests of the domiciliary midwives.

Let us not underestimate the power and influence of the NZNA and their extreme opposition to domiciliary midwifery. To deal briefly with the former. The NZNA Handbook states that NZNA provides the formal method whereby nurses are able to voice their independent opinion to Government, Departments of Health & Education, Hospital Boards Assn, NZ Medical Assn and the Nursing Council of N.Z. Meetings are held with these groups. They claim that they support or oppose measures proposed or introduced by these above bodies while the Nursing Council of N.Z., which is responsible to the Minister of Health, acts as a pressure group to influence policy decisions. President of the Nursing Council is Ann Nightingale, a most vigorous opponent of home birth. The NZNA have proclaimed their opposition to domiciliary midwifery. In their Policy Statement, April 1981, they say they now have to "formulate policies that admit reluctant acceptance of a fait accompli" (domiciliary midwifery). They also recognise that they are unable to "bring positive sanctions against those who condone and support the trend to home confinement." However, there is nothing to stop them from starving us out of existence! In fact, the policies they have formulated and which have been recommended in the Maternity Services Committee (MSC) draft report, 'Mother & Baby at Home, The Early Days' are designed to eventually eliminate domiciliary midwifery.

Let us have no illusions as to the role of NZNA in any wage negotiations carried out by any organisation they are able to influence or control. A recent example of this power was indicated in the Minutes of DMS, 31.10.81 wherein Shona Carey as Executive Director NZNA protested that domiciliary midwives could charge any fee they so desired. The decision of Ak HBA to ask domiciliary couples to augment the midwife's paltry wage by paying $75 came out of a meeting of the Auckland domiciliary midwives with Prof Bonham who suggested that domiciliary midwives should/could improve their economic status by making a charge to the patient rather than expecting the Department to increase its payment. However, the above mentioned MSC draft report now says: "When a midwife is under contract with the Minister of Health she must accept these fees in full for payment for her services and she may not charge the patient nay fee in addition." Would we be wrong in suspecting that Ann Nightingale and Shone Carey had a finger in this?

Obviously we can expect only sabotage from NZNA, NZ Nurses Industrial Union of Workers or CSU. Even NZNA recognise that any group needs an organisation to protect its interests. Who is going to protect the interests of the domiciliary midwives?

My suggestion is that we affiliate with the Federation of Labour (FOL). The CSU combines its efforts with the FOL when necessity requires. Even Shona Carey suggested in an Editorial on a recent Tribunal decision that if justice cannot be gained through the recognised negotiating machinery then nurses may have to resort to different strategies and actions. (NZNJ Aug 81) Auckland Branch NZNA also claim they are no longer prepared to sit back and complacently accept whatever is handed out. Probably neither of them would toy with the idea of directly joining the FOL as the NZNA fear unions they do not control. The NZNA sought legal recognition as an employee organisation in 1969 because "if it had not been prepared to work at its union function then other unions would have moved in to organise nurses - as indeed is happening now in the USA." (NZNJ, Nov 1981)

The 1969 State Services Conditions of Employment Act and 1977 legislation gave NZNA recourse to union strategies and benefits - recourse to conciliation and arbitration machinery and linkage into the annual state adjustment system - while still maintaining their elitist status and "control of nursing education, practice and standards." (And what a mess they have made of that so far as midwifery training is concerned). Their "great fear (was) that such unions would eventually speak for the profession" thus wresting the control of nursing education, practice and standards from them.

Since we are basically serving people rather than our own self-interest we need not share the fears of the NZNA. In fact the FOL could probably be of assistance to us when the crunch comes. The MSC draft report recommends that domiciliary midwives' "contract be with the hospital board rather than the Minister of Health" (p 17) while the Obstetrics Standards

Review Committee (OSRC), with the addition of a midwife, would be the appropriate body to make recommendations on the approval of such contracts. (p19)

There is a precedent for this alliance with FOL. In Wales in 1975 the Royal College of Midwives joined the Trade Union Council (TUC) and the coal miners went out on strike and obtained for all the midwives a substantial increase in wages, bringing them in line with other workers. However, being such a small group we could not expect such an all-out response, but FOL sponsorship would certainly add some clout to our demands. In recent wage negotiations the primary teachers claimed they lost because they did not take strong industrial action.

As instructed in Domiciliary Midwives Society (DMS) Minutes 31.10.81, I have made preliminary enquiries regarding affiliation with FOL. The first essential is incorporation which is well under way. The next step is to write to Ken Douglas, Secretary, FOL, P.O. Box 6161, Wellington 1 outlining why we are unable to use our professional organisation as a negotiating body, and why it is against our interests to use the other available negotiating bodies which are under the influence of NZNA. We should also include a copy of our rules. I would suggest that this document be used as the basis of our argument.

Affiliation with FOL would cost $1.25 per member p.a.

We would then proceed to prepare a submission outlining how and what we are paid, the number of domiciliary midwives, the services we render and a comparison of rater of our pay increases in relation to those of nurse/midwives working in approved areas to show the level of discrimination. This submission should be sent to the Director General of Health along with an accompanying letter requesting a personal interview. Copies of the submission should also be sent to Minister of Health, Aussie Malcolm and the Labour shadow minister of health, ~~Mike Moore~~ Ann Hercus.

The delegation chosen to aegue the points with the Director General of Health should be a strong one and include a person knowledgeable in industrial negotiation and possibly a lawyer.

Should this not provide the desired response then matter would then be turned over to the FOL.

On the basis of the above I move that as an incorporated body, the Domiciliary Midwives Society affiliate directly with the FOL and negotiations proceed immediately.

Joan Donley.

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Herewith are the rates paid to domiciliary midwifery with dates of increase since inception in 1939

| Service | 1941 | 1948 | 1955 | 1956 | 1965 | 1971 | 1975 |
|---|---|---|---|---|---|---|---|
| A/N visit | .... | .... | .... | .... | .... | .... | .... |
| Labour: with dr | £1 | £1 | £1 | £1.10 | £4 | $11.50 | $20.00 |
| no dr. | £2 | £2 | £2 | £3 | £4 | $11.50 | $20.00 |
| P/N visit | 5s | 5s | 7/6 | 10/6 | 16s | $2.25 | $4.00 |
| Live-in, per day | 13s+ | 18s+ | 27s | 27s | 54s | $7.50 | $13.25 |

| Service | 1977 | 1980 |
|---|---|---|
| A/N visit | $ 3.00 | $ 4.25 |
| Labour | $25.00 | $36.00 |
| P/N visit | $ 5.00 | $ 7.25 |
| Live-in | $17.00 | $24.50 |

Only one A/N visit is paid for. 14 P/N visits are paid for. In the first three days it is required to visit twice a day but only one visit is paid for.

+ This could include either the midwife taking the patient into her own home or staying at the patient's home. In either case the sum was not to exceed 30s p.w. in 1941 and £3 p.w. in 1948, any excess being met by the patient.
I would suggest that this establishes the precedent for the midwife to make an extra charge to the patient if she so wished. Whereas now the MSC arbitrarily state that this is not allowed!

RE: NZNurses' Ass'n 'POLICY STATEMENT ON MATERNAL & INFANT NURSING'.

Recommendation No 13: "That NZNA formulate criteria that will ensure a continual updating of the skill and knowledge of all practising midwives."

Although this recommendation appears reasonable, it is in fact deceptive and discriminatory. As the preamble to Recommendation 13 and Recommendation No 14 clearly indicate they are aimed at the domiciliary midwife, not at "all practising midwives." The NZNA even recognise that they have created a "dilemma" in proposing conditions of practice for one group of its members when none similar exist for other practitioners in midwifery in other settings. (p 17)

Recommendations 13 & 14 are difficult to analyse as they are devious and hypocritical. On the one hand the NZNA pays lip service to domiciliary midwifery. Then, as the self-appointed guardians of the consumers it feels forced to "formulate policies that admit reluctant acceptance of a fail accompli." The proposals are discriminatory, unrealistic and restrictive; they do not apply to midwives working in obstetrics (abnormal birth, only to those working in midwifery (normal birth).

If the NZNA were, in the past, meeting its "responsibilities to the consumer" why was it necessary to issue 'Obstetrics and the Winds of Change'? This says, "We in the medical and nursing profession face a major challenge to meet the demands of a vocal minority, as well as the larger needs of the majority...To try to justify our old practice and to be questioned about our traditional roles and rituals makes us feel uncomfortable (and threatened."

It is because domiciliary midwives have replaced "rigidity with flexibility" and have met consumer needs that the "vocal minority" is growing by leaps and bounds. Even though NZNA admit that "the health services, nursing included, exists for the benefit of the consumer"(p12) and that happily the childbearing public no longer accepts, passively, control of their lives by "the professionals", did they consult any consumers when formulating controls for domiciliary midwives?

The well-known consumer advocate, Ralph Nader, speaking to a forum 'Alternatives in American Childbirth' told his audience, "The medical profession has succeeded whether actively or passivly in undermining the development of health education, self help reliance and self help care." He claims doctors intimidate consumers into thinking they do not have enough knowledge to be able to care for themselves, while the medical profession has a monopoly on health care by controlling the assistant specialty groups (nurses, midwives, etc) while the consumer tends to lose in the deal.

<u>Every</u> midwife should be required to show a certificate of competence after two year's staffing in an obstetric or maternity unit. This is especially essential in view of the elimination of the practical midwifery course and its replacement with the midwifery option to the Maternal & Infant Nursing course which provides only eight weeks practical experience. Although no one would question the necessity for competence acquired through experience and education, it is certainly questionable that two years in a base obstetric unit is the kind of experience beneficial to a domiciliary midwife. The inability of NZNA to understand the demand for home birth is expressed in its statement "the hospital is just another aspect of community health." The heirarachal structure of hospitals which function to legitimise power are one of the reasons women are rebelling against hospital birth. Another reason is control of their bodies by a male dominated obstetric service. This is part of the feminist movement. Also, the reality of the hospital system is that a great deal of time is spent learning to use and depend on technology. This works against the basic philosophy of domiciliary midwifery which is really to guard the normal labour against the abnormal. How can a midwife trained in an heirarchal system, reinforced with technology possibly act with competence in the domiciliary situation? How can she relate to normal births when the basis of her training teaches that "birth is not a normal physiologival function at all" and home birth is "Russian roulette"?

It is all very well to advocate alternatives to home birth such as planned early discharge and "improvement of the existing hospital services" with unnecessary technology and procedures being avoided. (p21) This is highly unlikely. Professor Wright in Maternity Service Committee minutes (22.4.81) said routine technical monitoring was here to stay and women had to be persuaded to use this equipment. Furthermore, MSC Draft Report, 'Mother and Baby at Home The Early Days is based on the recent English 'Short' Report which advocates 100% hospital delivery with <u>every</u> labour electron-

ically monitored. Visiting Professor Richard Beard who claimed home birth is Russian roulette, was one of the three expert advisers to the Short committee!

NZNA attacks domiciliary midwifery on the basis of economics. It says, "The health care system can ill afford to develop a service for a minority group when within the hospitals there exist problems of finance and personnel....In times of financial constraint cost-effectiveness of a service is paramount." (p21) From the cost-effectiveness point of view home birth relieves the state of vast sums. The home birth parents meet all the capital and service costs. They provide the domicile, the bed, the linen and laundry, the food, the home help. This does not cost the overburdened health service a penny! But to have a baby in hospital costs the state at least $190.00 a day. The midwife's service costs the Dept of Health $141.75 (for one A/N visit, labour and 14 days P/N care) plus a mileage allowance. This total care costs less than one day in hospital. How can you get more cost-effective than that? What's more the consumers are satisfied!

The suggested geographic limitation of a maximum of one-half hour's drive from a maternity or obstetric hospital, is unrealistic. If the interests of the consumer are really important, what is NZNA doing about the women who are having to drive two, or even three hours, unattended in labour, to reach a base hospital due to the closure pf so many small maternity annexes? Has there been a protest on that account?

And finally, the procedure and method of presentation of this Policy Statement has been undemocratic and irrational. The Policy Statement on Home Confinement was presented to the Maternity Services Committee before it was approved by the membership. This was pointed out to MSC in a submission by the domiciliary midwives. It was then railroaded through the 1981 NZNA Conference on the basis that it could be discussed later. Meanwhile all the recommendations concerning domiciliary midwifery are contained in the MSC Draft Report, Mother and Baby at Home the Early Days. The NZNA are now discussing the recommendations - an exercise in futility. They are a "fait accompli."

There appears to be only one solution to the NZNA "dilemma"; that is the institution of a hospital associated, basic and practical midwifery course. Such a course was mooted at NZNA 1980 Conference when a remit presented by the midwives and obstetric nurses section was passed and which the NZNA "is currently addressing its substance." In the interests of the consumer this course would of course include training in domiciliary midwifery - in the field with a domiciliary midwife.

Such a course would also end the current debate about 'What is a Midwife?'

It would also automically eliminate the restrictive practice regulations applying to domiciliary midwives. It would also probably relieve the midwife shortage which is basically midwives refusing to practice in the field of obstetrics rather than midwifery. It is not very flattering to NZNA when nurses are going to Australia and UK for midwifery training. If the NZNA do not provide midwives, especially for domiciliary service, then they will find that the consumer will resort to lay midwives as they have done in America. It has also happened and is happening in rural areas here where women cannot get to where there is a domiciliary midwife. In fact, it was quite prevalent in Ponsonby before consumers felt confident with the domiciliary midwives. Does the NZNA want to contribute to that situation?

To sum up the recommendations concerning domiciliary midwives bear litte relation to the N.Z. reality. They should be scrapped in favour of a basic practical midwifery course with domiciliary content. The feminist/ alternative life style movement is strong and growing and includes many professionals. Pretending it does not exist will get the NZNA nowhere, neither will rhetoric and more lip service to consumer health needs. The NZNA express their desire to become "a powerful political group". Only the mass support of the consumer can provide that. Since historically nursing developed to serve the needs of the medical profession, unless nurses throw off their elitist professional stance they will become merely an atrophied appendage of the medical profession; or fall between two stools. That is the real 'dilemma of the NZNA.