20001-43-040

The New Zealand Home Birth Association

Box 11-412
Wellington

12 October, 1983,

The Secretary,
Committee on Health and welfare,
Government Research Unit,
Parliament Buildings,
Wellington.

Dear Ms. Rasch,

The New Zealand Home Birth Association Inc. would like to make the following submission to the Committee regarding the state of domiciliary midwifery in New Zealand today.

There are two areas in particular which give us cause for concern, and we ask the committee to consider these and make recommendations to the Minister of Health on our behalf.

The areas of concern to us are:

1. The fees paid to domiciliary midwives.
2. The Maternity Services Committee Report: "Mother and Baby at Home: The Early Days," which is at present before the Minister awaiting his decision to be implemented.

1. FEES PAID TO DOMICILIARY MIDWIVES.

Until October 1982, a domiciliary midwife received a total of $145.00 per maternal case (one antenatal visit, the labour and delivery, and 14 days' post-natal care). On a full caseload of around 50 deliveries per year, she receives $7,250 per annum.

In October 1982, the Minister of Health allowed a 17 % increase. This brings a midwife's income up to $8277.50 per annum. Because of the Wage and Price Freeze, however, the midwives have not been able to receive this increase.

A hospital midwife receives between $13,411 and $16,411 per annumdepending on length of service.

The New Zealand Home Birth Association believes that a domiciliary midwife is intitled to the same pay as her hospital counterpart. The present difference in pay is discriminatory and unjust. We therefore call for a 50% increase in the pay of domiciliary midwives.

In the present situation, an increase in pay rests solely in the hands of the Minister of Heal th.

The present Minister of Health, Mr. Malcolm, has toldthe Domiciliary Midwives' Society that it should negotiate further increases through a recognised negotiating body and cited the New Zealand Nurses Association as a suitable medium.

However, the NZNA cannot negotiate on behalf of domiciliary midwives because, it says, 'we are an employee organisation which is recognised by Government as the negotiating body for nurses employed in public general ormaternity hospitals. It is not possible to negotiate salaries for self-employed persons'.

The Minister has also stated that 'there are no plans to give domiciliary midwives parity with hospital midwives; indeed, that would not be possible, as the basis for payment is quite different, the former being on a fee for service basis and the latter on a salary basis.'

We insist that the difference in the basis for payment is not a reason for denying parity, and that parity can be assessed on the basis of a full caseload.

It seems further illogical to us, that the Minister of Health should see fit to advise the Domiciliary Midwives Society to apply for an increas through the NZNA just after having granted a 17% increase to them as aresult of a direct appeal made by this Society.

It can be seen that the situation of payment for domiciliary midwives is a peculiar one in which they are termed 'self-employed' yet receive a fee for their services from the Department of Health.

We assume that the Health Department is required to pay this fee because the Government supports the legal right of New Zealand Women to choose where to give birth.

The Minister of Health and the Director General of Health have both stated that 'the present pay for domiciliary midwives was never intended to be a full-time salary'. The pay which a domiciliary midwife receives is in fact a 'benefit' which is really a maternity benefit for the consumer of the sefvice, not the midwife. Does this mean that the domiciliary midwife could, like a general practitioner, charge her own fees in order to make a living out of her profession? Not so. The present regulations state that a domiciliary midwife is not permitted to charge her patients privately if she is receiving the 'benefit'. So, in fact, she is neither paid by the Health Department, nor by the consumer, yet she is 'employed' by the Health Department, and paid by the Division of Clinical Services, Head Office.

This situation is unsatisfactory and in need of urgent attention.

If the Maternity Services' Committee's recommendations of having domiciliary midwives employed by the Hospital Boards is implemented, then the situation could be as follows:

1. The NZNA would be able to negotiate effectively on behalf of domiciliary midwives for an increase in fees.
2. The present 'benefit' system would be discontinued and the hospital boards would employ the domiciliary midwives in the same way as hospital midwives.

The NEW Zealand Home Birth Association does not support the idea of domiciliary midwives being employed by the hospital boards, for reasons set out in the Association's submissions sent to the Minister of Health regarding the MSC Report (copy enclosed).

We support the idea of domiciliary midwives being employed by the Head Office of the Department of Health, as at present, with payment for her services done in the same manner, i.e., through a claim form sent into the office after each case, but at a rate which would bring her annual income up to a level which would support her fully.

We believe that it is just and fair to expect this of the Health Department as a service to the New Zealand mother who chooses to be confined at home. The Health Department provides a free hospital maternity service to New Zealand women, it should likewise provide a free home maternity service for those women who choose to have their baby at home.

Since the present Government has stated that it acknowledges the right of women to make this choice, it is legical that it should make that choice areality by ensuring that domiciliary midwives receive adequate pay for their services.

The present poor renumeration of domiciliary midwives is the main reason why there is a shortage of domiciliary midwives in a number of areas, but particularly in Auckland and Wellington.

The demand for home births in the Auckland area is around 600 per year, enough to keep 12 domiciliary midwives fully emlpoyed. In Wellington and t he Hutt Valley, the demand is around 60 per year. Both these areas have over the past six years seen a steady increase in the demand for home births and had enough domiciliary midwives at one stage to satisfy the demand. There are midwives available and willing to do domiciliary midwifery, but they are being forced out of their chosen profession because of the poor renumeration. The Wellington area is now without a midwife and Auckland has only two midwives. In both areas, mothers are taking a risk of having their babies at home without the services of a domiciliary midwife, putting undesirable strain and responsibility on their GPs who have to attend reluctantly.

We are also concerned that the unavailability of domiciliary midwives will lead to an increase in 'lay midwifery'. The dangers of this situation are yet another reason why the Health Department must act to ensure the availability of domiciliaty midwives to meet the demand in the community.

We would conclude with the statement that the espousal of the principle of freedom of choice by a health care system enjoins upon that system an obligation to provide alternatives.

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2. The Maternity Services Committee Report, "Mother and Baby at Home: the Early Days".

This report contains a number of recommendations which the Home Birth Association considers to be unnecessary and unwarranted. We enclose a copy of our national submission to the Minister of Health for your examination. We ask you to consider our comments and represent our views to the Minister whilst he is considering the report for implementation.

The New Zealand Home Birth Association.

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Henriette Kemp (President)