20051-5-003

1. THIS CONTRACT DEALS ONLY WITH DOMICILIARY MIDWIVES AS PRIVATE/INDEPENDENT PRACTITIONERS HAVING ACCESS TO AUCKLAND AREA HEALTH BOARD FACILITIES ON THE SAME BASIS AS GPS.

1.1. The Area Health Board Act 1983 has been amended to provide for registered midwives to have access to any maternity hospital, maternity ward or maternity annex under the control of an area health board on the same basis as medical practitioners. (Information for Health Providers)

This is one aspect of legislation giving midwives independend status. It came about as a result of lobbying by the N.Z. Homebirth Association and the domiciliary midwives in response to the progressive medicalisation of childbirth. It was further promoted by the Cartwright Inquiry and the Government's committment to primary health care. It also had the blessing of Treasury, as cutting down on duplication of services is seen to be cost effective.

1.2. This Submission deals only with access to the Board's maternity facilities on the same basis as GPs, which under the present contract provides access to the Board's facilities and resources; these include referral to hospital consultants and support of midwifery and ancillary staff - which is now creating problems

There are differences in GP use of resources, depending upon whether a woman is booked for labour and birth, or only for use of resources in case of transfer from a home birth. The latter is to ensure continuity of care based on the right of a woman to the doctor of her choice and to guarantee that doctor's continuing role in decision-making.

Domiciliary midwives seek a similar right to book women into hospital to enable the midwife to continue the woman's care in case of transfer, with access to relevant consultant services.

2. THE BASIS OF THIS CONTRACT IS AMENDMENT TO S 49 OF THE AREA HEALTH BOARD ACT, FOR ACCESS, NOT TO BE CONFUSED WITH DOMINO CONTRACTS.

2.1. DOMINO births are different in essence. A woman planning a home birth is providing the domicile and the facilities while the midwife is supplying the equipment and the transport. The responsibility is shared. **This is primary health** care and is well established in Auckland.

2.2. Transfer to the secondary (hospital) sector is on the basis of need for referral. The 1978 Declaration of Alma-Ata postulated that primary health care "should be sustained by integrated, functional and mutually supportive referral systems..." (Item 6). This has, in fact, been happening.

2.3. In the DOMINO option both the woman and the midwife are dependent on the facilities, equipment and resources

supplied by the Board; and this dependence has been encouraged for more than 50 years.

2.4. AAHB has made a committment to both continuity of care and to DOMINO births. In fact, a priority for Central Auckland, 1991/92 is establishment of continuity of care and development of midwifery practice schemes for public and private patient management. (While the word 'management' is questionable, the intent is to be applauded).

However, the differing concepts between home birth transfers and DOMINO births are reflected in the debate over payment for these services.

2.5. Midwives planning to do mainly DOMINO births are applying for domiciliary contracts. The domiciliary contract, 1987, is based on S 110, Social Security Act and enables the midwife to claim fees fixed by the Minister while practising outside an institution under the control of an area health board.

If a board promotes a contract DOMINO scheme and expects the Maternity Benefit to pay the midwife, it is not only transferring to Maternity Benefits costs for which the board is responsible, it is also contravening the terms of the domiciliary contract. Neither is it appropriate nor acceptable for a midwife to classify a planned DOMINO as a home birth transfer; this undermines the primary health care aspects of domiciliary midwifery and distorts the home birth statistics.

2.6. The Northland AHB's pilot DOMINO scheme (developed prior to midwifery autonomy) paid the midwife on the basis of the rates paid by the Maternity Benefit.

2.7. Obviously, the Maternity Benefits sections of the Social Security Act are in need of review - not only because of the anomalies, but also because it is based on the medical model of childbirth and the dominance of the doctor; for example, the doctor is paid for "medical services" while the midwife is paid for "services rendered". (Appendix 1)

Originally, the payment of 'medical services' had "no application with respect to patients in any State maternity hospital" (S 114), although S 115(1) empowered the Minister "from time to time, subject to such conditions as he considered necessary (to) approve the grant of maternity benefits to every woman to whom medical services are rendered in a specified State maternity hospital by a practitioner selected by her".

At the time this Act was formulated, 1938, public maternity wards provided mainly emergency services while the majority of maternity beds were in private hospitals - 1098 private beds of a total of 1707 beds. (Appendix 2)

2.8. A recent communication to the N.Z. College of Midwives from Benefits personnel notes the differing roles of midwives and medical practitioners in relation to pay equity and requests the College to examine the appropriateness of the payment structure.

2.9. The irregularities do not apply only to midwives. GPs book women into hospital. Throughout labour, the staff midwives, as part of the resources, do the donkey work, while the doctor breezes in for the birth and collects $285 for up to 1½ hours attendance; alternatively, when a GP does provide some support during labour then claims from Maternity Benefits at the rate of $69.80 for each half hour or part thereof in excess of 1½ hours.

2.10. AAHB is not the only Board struggling with the problems of new contracts based on old concepts. In discussion re contracts, the Christchurch Focus Group (who apparently do not feel threatened by having their comments made public), Dr McKean observed that obstetrics is the only part of the Board's service where private practitioners carry out part of their private practice in Board facilities; Dr Holmes said it was his understanding of the Social Security Act that no payment could be made for private care delivered in a public hospital where the woman's care was the responsibility of the hospital. (Official Notes of Seventh Meeting, 24.10.90)

2.11. Until such time as these anomalies are sorted out at national level, we recommend that the Board

(a) Begin serious negotiation for a DOMINO scheme based on Bev Crombie's continuity of care team of midwives on salary, based in the community but using part of the vacated DU Ward 2 for births;

(b) Investigate an option suggested in Information for Health Providers, for midwives to be "self-employed on contract with the area health board with pay and conditions negotiated between the parties" (p 9) and with support from the NZNA delegates and the union.

3. THE CONTRACT SHOULD BE DIRECT, BETWEEN THE CONTRACTOR AND THE BOARD.

3.1. Since the Board provides the facilities and the resources, and is legally responsible for the welfare of the patient while she is under the Board's care, we feel that the contract should be a direct one between the contractor and the Board. i.e. there is no need for an intermediary broker such as the OSRC, or any extension of this relic of the past for example, a Maternity Services Review Committee.

3.2. According to the official rhetoric, the OSRC was set up in 1979 to 'establish and monitor obstetric standards in New Zealand'. On this basis, since 1981, it was accorded 'sufficient authority to review contracts and make appropriate recommendations to hospital boards'. (Appendix 3)

However, the OSRCs have no structure for monitoring and/or review. Also, it was noted by the Working Party that since GPs are "outside the service" and having no relevance to the Board's disciplinary structures there has been dissatisfaction with the way the OSRC has functioned.

3.3. It is interesting to note that as far back as 1938, the Social Security Act (S 115(2)) required the medical practitioner to enter into an agreement with the medical superintendent on terms approved by the Miniter, in order to claim the Maternity Benefit in a State maternity hospital.

3.4. Today, the Review Committee of the Board has assumed the overall responsibility for monitoring standards of care and auditing complaints by patients. Already several procedures are in place: AAHB's Complaints Procedure;
Performance Indicators;
Quality Assurance Programme.

The AAHB Complaints Procedure states that complaints should be handled promptly and initially at the "local level, as close as possible to where the concerns arose".

Any intermediary committee would surely delay 'prompt action' and could undermine the entire procedure. If the Board's Complaint Procedure is to be effective and protect the Board's responsibilities, contractors need to be directly accountable to the Board by whatever mechanisms that are mutually established, and the Board should have the power to act directly.

3.5. 'Performance indicators' are included in the Board's contract with the Minister. Their purpose is to measure 'outputs' (goods and services) over which boards have accountability control. The National Health Indicators Monitoring System has formulated performance indicators as a dataset which were effective from July 1990 and are subject to annual review.

In addition, AAHB's computerised data audit for maternity services, operational from January 1991, provides performance indicators for individual health professionals which will reveal intervention and complication rates.

We understand that there is to be a full-time consultant in charge of each DU who will oversee the service.

3.6. One of the three principles of the Board's Quality of Service Policy is:

3.3. Quality must be assessed as the effect of the service on the outcome for the consumers.

It comments: 'The focus is on good service - on "getting it right" for the consumer, rather than a prescription of specific standards, audit or mechanisms for measuring processes.

'Externally defined standards have a place in this process, but must not overrule a realistic assessment by those who use and provide the service as to what is good quality service.'

There is no need to overreact.

4. TERMS OF CONTRACT

1. Professional standards should be basic.
   For midwives:
   (a) Registered midwife, with or without nursing qualification;
   (b) Current Annual Practising Certificate (APC)
   For GPs
   (c) Diploma of Obstetrics
   For both
   (d) Two references.
2. Orientation for midwives who have not had recent experience in the secondary sector.
3. Initial contracts should be provisional with right of renewal.
4. Subject to termination by either party within a time frame.
5. To protect the contractor's interest, there should be a right of appeal with support of witnesses and legal counsel if desired.

4.1. Current midwifery education is based on three years comprehensive nursing plus one year of intensive midwifery. The Nursing Council of New Zealand sets the standards for both the nursing and the midwifery courses; and sets the exams which are marked by selected examiners who are experienced nurse midwives. It also issues the APCs. The Nursing Council is a statutory body responsible for nursing/midwifery curricula, registration and on-going monitoring of standards. Nurses and midwives are subject to the disciplinary process of the Nursing Council on the basis of a complaint, just as doctors are subject to the disciplinary process of the Medical Council.

5 OBLIGATIONS OF CONTRACTORS

5.1. With certain reservations, contractors would expect to be subject to the Board's

(a) policies and protocols;
(b) disciplinary procedures;
(c) quality assurance programmes.

and these should be specifically spelt out in the appendices to the contract.

5.2. An adjustment to the disciplinary procedure is necessary since contractors are not in the Board's employ.

Similarly, with quality assurance programmes. AAHB's Quality of Service policy recognises that 'as each service differs, the ways to demonstrate quality will be different and quite specific for each service.' (3.2)

For maternity care in general, it will be based on pregnancy and birth as normal processes, women's right to information and role in decision-making and continuity of care - all of which have been incorporated in Auckland Maternity Services: Strategic Directions.

5.3. In relation to domiciliary care, it should also be recognised that women opting for home births are generally well informed and prepared to accept responsibility for their decisions. They see themselves as part of a symbiotic team with their midwives.

6. INDEPENDENT MONITORING PROCESS

6.1. It is from this relationship that the Domiciliary Midwives Standards Review Committee (DMSRC) was established at the N.Z. Homebirth Conference, 1988, operational at a regional level.

Each domiciliary midwife is required to present a written review of her year's work plus a self-assessment. The monitoring committee is comprised of four health professionals and four consumers. The consumers are women who have had a home birth, nominated by the local HBA. The health professionals include Carol Petersen (formerly PPHN) representing the Board; a GP who supports home births nominated by the HBA; a domiciliary midwife nominated by the Domiciliary Midwives Society Inc; and a hospital based midwife nominated by the NZCOM

These reports are now being put on computer. The DMSRC could provide a reference for a midwife seeking a contract.

6.2. The Board should be aware that the consumers on this committee have put in many hours of time and energy on a voluntary basis. It is high time that they be paid for their contribution. This could be negotiated under either S 31(1) or S 29 of the Area Health Board Act.

6.3. We recommend that the doctors organise a similar review system to monitor private/community maternity care

7. DOMICILIARY MIDWIVES ARE PRIMARY HEALTH CARERS.

7.1. This application for a contract should not raise false hopes that domiciliary midwives/home birth movement are prepared to become incorporated into the hospital heirarchy. Domiciliary midwifery is primary health care, hospital care is predominately based on the medical model of childbirth. (Appendix 4)

7.2. In fact, AAHB lawyer, P. Moran commented at a WP meeting (29.10.90) that such supervision would be "too difficult to monitor". Especially so since it would have to include the GP community practice.

7.3. Moran also noted that the Area Health Board Act is to promote decentralisation, while hospitals are centralised. Centralisation reinforces power. "A single administrative core reserves to itself the right to transmit power through a heirarchy to those who fulfill its requirements. One of these requirements is uniformity". (Marilyn French, Beyond Power: Women, Men & Morals, 1985, p 160)

7.4. The Area Health Board Act is based on the WHO concept of Health for All by the Year 2000, i.e. primary health care. But hospitals are clinging to the old centralised/regionalisation model which fosters take-overs. WHO considers that "getting hospital staff to change their ways of working is likely to be no easy matter". (Paine & Tjam, Hospitals and the health care revolution, WHO, 1988, p 47)

7.5. The WHO Expert Committee report on Hospitals and Health for All points out that hospitals are bureaucratic structures, and sees "the right to refer across boundaries is...an important protection against bureaucracy" (Ibid)

This report also points out that overemphasis on the disease model and lack of contact with a defined community have caused hospitals to lag behind community health initiatives. "These attitudes must change if hospitals are to play their proper role in primary health care". ('role', not control)

Further, "...with resources becoming increasingly scarce, hospitals have no right to decide for communities that they serve, which health issues should be given priority; technical decisions are one thing, but choices of priority are generally at least as much social and political as technical". (Ibid p 50)

7.6. WHO warns that: "It is clear that unless hospitals accept a partnership role and function in an integrated way with other services in the community, a fragmented local health system will persist. Hospitals should adjust to understand better the essential needs of the community they serve by developing an unprejudiced dialogue with all concerned with health, as equals engaged in the question of Health for All.

"Governments, nongovernment organizations and international organizations should promote this essential understanding so that antagonisms may be converted into effective collaboration, thus ensuring the positive role hospitals must play in support of primary health care." (Ibid p 112)

7.7. With the support of the Homebirth Association, domiciliary midwives will continue to initiate change, moderate attitudes and promote options in maternity care, as they have done in the past.

Any 'take-over' would destroy this initiative.

Therefore, the domiciliary midwives must remain under the Board's primary health care sector, i.e. the Health Development Unit.

Appendix 1

110. Services of registered midwives and maternity nurses—(1) The Minister may from time to time fix the fees to be paid by the Department in respect of the services of approved midwives and approved maternity nurses for services rendered by them in providing maternity benefits in accordance with this Part of this Act, and the terms and conditions subject to which such services shall be rendered.

(2) Every registered midwife and every registered maternity nurse shall be approved for the purposes of this Part of this Act who signifies to the Minister in the prescribed form and manner that she is willing to carry out the duties of a midwife or maternity nurse in consideration of the fees and on the terms and conditions fixed by the Minister.

Cf. 1963, No. 47, s. 25

114. State maternity hospitals—(1) Except as is provided in subsection (2) of this section and in section 115 of this Act, the foregoing provisions of this Part of this Act as to maternity benefits shall have no application with respect to patients in any State maternity hospital, and no charge shall be made in respect of the confinement of any woman in any such hospital.

(2) If any woman who is not entitled under section 91 of this Act to claim maternity benefits receives treatment in a State maternity hospital, such reasonable charges as the Minister approves may be made in respect of that treatment.

Cf. 1963, No. 47, s. 29

115. Maternity benefits in respect of State materntiy hospital—(1) Notwithstanding anything in section 114 of this Act, the Minister may from time to time, subject to such conditions as he considers necessary, approve the grant of maternity benefits to every woman to whom medical services are rendered in a specified State maternity hospital by a medical practitioner selected by her.

(2) Without limiting the general power to impose conditions conferred by subsection (1) of this section, the Minister may as a condition of his approval require that the medical practitioner by whom the services are rendered shall have entered into an agreement with the medical superintendent for the time being of the State maternity hospital, acting on behalf of the Crown, in terms approved by the Minister as to the conditions on which the medical practitioner is to be entitled to treat his patients in that hospital.

(3) Where any woman is entitled to maternity benefits pursuant to subsection (1) of this section, sections 111, 112, and 113 of this Act shall apply with respect to medical services rendered to her.

(4) The Minister may withdraw in whole or in part any approval given by him under subsection (1) of this section, and may from time to time modify, add to, or revoke any conditions imposed by him under that subsection.

Cf. 1963, No. 47, s. 30

Appendix 2

HISTORICAL DEVELOPMENT OF ACCESS.

GP access to public maternity hospital services developed from the Social Security Act, 1938.

The Hospital Benefit introduced in 1939 provided 'free' hospital care for the patient, hospital boards being paid a government subsidy per occupied bed per day. It was in their interests to keep beds occupied.

Prior to this legislation, physicians and surgeons provided unpaid, part-time 'honorary' service. "When hospitals ceased to be exclusively benevolent institutions it was no longer incumbent upon the profession to give honorary service". (Lovell-Smith, The New Zealand Doctor & the Welfare State, 1966 p 109). Instead, doctors accepted positions as part-time stipendary staff. Today, this is the basis for consultant contracts based on 'tenths'.

GP access to public maternity hospitals developed as a result of the Maternity Benefit, 1939. At that time there were only 524 beds in 84 public hospitals, mainly for emergency/surgical conditions. Most beds were in the 189 private hospitals which provided 978 beds, plus 120 one-bed maternity homes. The four St Helens hospitals provided 85 beds (midwifery care). (Paget, T.L. 1939)

The Social Security Act S 114 (1) stated that maternity benefits "shall have no application with respect to patients in any State maternity hospital..." However, in his Annual Report, 1939, T.L. Paget, Director of Maternal Welfare, encouraged doctors to use the public services. He said:

> The provision of maternity hospital benefits under the Social Security Act will relieve the ratepayers of a large part of the maintenance costs. This should go far to help the more reactionary boards to overcome their tendency to be over-economical in the provision of maternity hospitals in reasonable proximity to patients and doctors without which the best results cannot be obtained.

Also, S 115(1) of the Social Security Act empowered the Minister "from time to time, subject to such conditions as he considers necessary (to) approve the grant of maternity benefits to every woman to whom medical services are rendered in a specified State maternity hospital by a medical practitioner selected by her".

GP access to public hospitals therefore developed because of the state subsidised relationship between the woman and her GP. The combination of the Hospital Benefit and the Maternity Benefit encouraged both women and GPs to opt for birth in hospital.

By 1971, 65.1% of all deliveries in N.Z. were conducted by GPs in their private capacity in public hospitals. (Maternity Services in New Zealand, 1976, pp 43 & 48). In fact, Maternity Services in New Zealand claimed that "most (maternity) hospitals were provided by boards solely as a place for mothers to be delivered under the private care of their doctors")p 5)

In 'obstetric units' being developed at the time of this survey, 20.5% of women were delivered under the hospital specialist services (clinical material) in 'closed' beds, although GPs still had access here to a limited number of en' beds.

LACK OF ACCOUNTABILITY

According to Sir Douglas Robb, "In neither of these benefits (Hospital/Maternity) was any significant gesture made nor action taken towards improvement of the quality of service on either a short or a long term basis". (Medical Odyssey, 1967, p 62)

However, the Social Security Act S 115(2) gave the Minister the power, as a condition of his approval of 115(1), to require the medical practitioner by whom the services are rendered to have entered into an agreement with the medical superintendent...on terms approved by the Minister as to the conditions on which the medical practitioner is to be entitled to treat his patients in that hospital. i.e. such accountability as existed in public hospitals was tied to the payment of the Maternity Benefit.

D.W. Beavan, 1974, claimed that "standards in general practice have not been assessed. Nor do hospitals have any form of medical audit or careful evaluation of standards of clinical care". (The Future of New Zealand Medicine, p 47)

This lack of accountability was echoed in Maternity Services in New Zealand, 1976, which found that the system of care provided on the basis of a private arrangement between patient and doctor "has led to boards abrogating responsibility for standards of private care in their hospitals". (p 86)

Further, "superintendents did not feel they had the background to advise general practitioners on how to carry out their obstetric practice whereas local specialists, if they were involved, were sometimes unwilling to comment unfavourably about practitioners who referred them a good deal of private work". (p 73)

It was estimated that less than one-third of GPs had a Diploma of Obstetrics. The Report advised that "we believe that a special evaluation system must be provided". (p 73)

Appendix 3

OBSTETRICS STANDARDS REVIEW COMMITTEES (OSRC), 1979.

In 1979 the Obstetrics Standards Reveiw Committee was established in accordance with a resolution of the New Zealand Medical Association Council "to present precise proposals for the establishment and monitoring of obstetric standards in New Zealand". (MAH Baird, Editorical, NZMA Auckland Division Newsletter, June 1980)

According to a Department of Health Circular Letter 1981/209, chief executives of hospitals boards were advised that the OSRCs were set up following discussion between the NZMA and the DOH to make recommendations to the Department "regarding control of obstetric practice by medical practitoners in obstetric units. .. The measures outlined in the annex to this letter (arrived at by consensus between the two groups) provide some measure of peer review in obstetrics and provide guidelines for the issuing of contracts granting access to "open" maternity beds".(Appendix)

While granting "sufficient authority (to OSRCs) to review contracts and make appropriate recommendations to the hospital board" the Department noted that "the Maternity Service Advisory Committee of the Board of Health does of course represent authoritative opinion on the broader aspects of obstetrics".

The Department provided a sample contract which is the one in use today.

HOW EFFECTIVE HAS THE OSRC BEEN IN IMPROVING STANDARDS?

Choices for Health Care - Report of Health Benefits Review, 1986 states that, "Measurement (or even definition) of quality in health services is difficult. In primary health care in New Zealand it is even more difficult because many of the providers are private practitoners.....Lack of accountability of providers is, however, characteristic of the whole health area and is as much - if not more - true for the hospital service as for general practice. Perhaps this is a result of how well established a benefit or grant is, and which group is involved". The Report found that CHIFS recipients "are asked for much more accountability than are hospitals or doctors". (pp 49/50)

During its brief existence the 'working party' on contracts noted that:

* while the OSRCs advise the Board re contracts, and this is the only advice that managers have, they are "outside the service" and have "no relevance to the Board's disciplinary structures".
* AAHB lawyer observed that there has been dissatisfaction in the past with the way the OSRC has functioned.
* The National OSRC has not met since 1987 and is an "anachronism".

In fact, the Department of Health Discussion Paper on Care for Pregnancy and Childbirth recommended that the OSRCs be disbanded.

A RELIC OF THE PAST.

The establishment of the OSRCs must be seen in a broader context than merely as a committee to 'monitor standards'. These were also a factor in the struggle to undermine the position of the family practitioner/surgeons who had a corner on market of gyn surgery and childbirth.

As pointed out in Maternity Services in New Zealand, "Historically the specialist gynaecologist appeared late relative to physicians and surgeons"; his acceptance in N.Z. was slower than in Europe or North America. This was seen as due to "the low population density, the tradition of the surgeon in the smaller centres and to the remuneration obtained by surgeons from private gynaecological operating in the larger centres" (11.0 p 57)

According to Robb, "the Government gave attention to general practitioner service first and foremost, leaving specialist services almost unprovided for". (Medical Odyssey p 86).

In the area of obstetrics, this Maternity Services Committee Report (Maternity Services in New Zealand) noted that, 1971, no specialist attended 132 of the 162 maternity hospitals (22.6); the private arrangement between patient and doctor "led to failure by boards to utilise their specialists in developing comprehensive services in line with modern concepts of clinical care" (22.16.3) and some boards were offering base obstetric facilities in the absence of the specialist gynaecologist. This was due to a tendency "to deal with major obstetric emergencies without skilled gynaecological supervision and to use instead a local surgeon, generally the superintendent, as a "technical plumber"....to perform caesarian sections on indications prescribed by the family practitioner..." (17.3.2 p 70)

This drive to specialist control of obstetrics and gynaecology was not a New Zealand phenomena, it was global.

According to William Arney, Power & the Profession of Obstetrics, this O&G speciality took control of childbirth by blurring the demarcation between 'normal' and 'abnormal'. It was built on its ability to treat childbirth as pathological; then, since doctors could not always depend on pathology being obviously present, to develop ways to "foresee" pathology and act prophylactically. By fostering the pathological potential, the 'residual normalcy' of childbirth could be accomodated. (pp 51 & 54)

The N.Z. referral guidelines are based on this philosophy and the mechanistic medical concepts of the 1950s (which have now given way to the ecological approach based on processes). Professor Rosenblatt claimed that N.Z.'s national referral guidelines "went far beyond the more tentative attempts at regionalisation in most other westernised countries". No doubt this was to make up for the late start and the entrenched position of GPs. However, Rosenblatt expressed concern about "the impact of increasingly stringent regulations on the future of general practice obstetrics". (Regionalisation of Obstetric and Perinatal Care in New Zealand - A Health Services Analysis, Department of Health, 1984 (unpublished), p 64)

In practice, the medical model of childbirth has become the norm. Reliance on expensive technology (most of which was not evaluated before use) has increased the costs of childbirth and aroused consumer opposition.

It has also, according to Arney, made decision-making more complicated and difficult. He says that a difficult decision is

is simply one for which no widely accepted, culturally prescribed resolution has been found. Therefore, groups involved in such decisions develop codes in order to legitimate the practice of the group and to keep outsiders from scrutinising those practices - a rhetorical device to unify a group and obtain social privilege and political advantage. (Arney p 34)

In fact, it was this unwillingness to have outsiders (eg consumers) scrutinising the process that caused dissention within the WP on contracts.

Even if the name is changed to Maternity Services Review Committee, is this the type of committee we want as the intermediary, or power broker, between the contractor and the Board?

Appendix 4

DOMICILIARY MIDWIVES ARE PART OF THE PRIMARY HEALTH CARE SERVICE & SHOULD WORK UNDER THE PRIMARY HEALTH CARE SECTOR OF THE AAHB.

HIDDEN AGENDA

In discussion re contracts for midwives not employed by AAHB it became evident that the managers of maternity services and Professor Colin Mantell have plans to take over supervision of community midwifery services, ég domiciliary midwives/home births.

Their rationale is that:

* The Area Health Board Act 1983 charges the area health boards with the responsibility of promoting and protecting the health of residents of its district; (S 10(a)) and
* Repeal of S 58 of the Nurses Act 1977 which gave the Medical Officer of Health supervisory powers over domiciliary midwives which were delegated to the PPHNs is seen as leaving the domiciliary midwives as up for grabs.

Two points here: There is more to the structurs of an area health board than the previous hospital board bureaucracy; and if domiciliary midwives, as independent practitioners are up for grabs, are GPs also?

BACKGROUND

Before midwives were accorded independent status, the pompous and retrogressive Maternity Services Committee (MSC) Report No 30, Mother & Baby at HOme:The Early Days, 1982, recommended that,

(10) The domiciliary midwives be based at the obstetric unit in the area, and the control of the domicilairy midwife for domiciliary confinements should be with the hospital board;

(11) Now that the review committee for obstetric standards have been set up by hospital boards, they should also review the midwive's contracts for domiciliary confinement in the community served by the hospital board.

The Report was frank in its opposition to home births.

The Homebirth Association challenged the MSC philosophical basis of birth as expressed in this Report and also in its previous report, Maternity Services in New zealand, 1976, which would place nearly every woman into the hands of a consultant during her pregnancy and/or birth.

OPPOSITION

In submissions to the MSC, both the HBA and the Domiciliary Midwives Society Inc pointed out that the inability of the MSC to understand the different roles of the obstetrician and the midwife made it "totally inappropriate" for obstetricians to assess domiciliary midwives.

A later letter to the Obstetrics Standards Review Committee, July 1989, said that 'since domiciliary midwives practice outside the parameters acceptable to the majority of obstetricians it would not be reasonable, nor politic for them to be assessed by those supporting the medical model of childbirth.

Marsden Wagner, WHO Regional (European) Officer, speaking at the N.Z. College of Midwives Conference, Dunedin, 1990, said the conflicting attitudes arose because midwifery generally functions with the social model (birth is biosocial, part of life and deals with people), while obstetricians function with the medical (reductionist) model (birth is a risky affair, women are 'patients' requiring control by experts).

AREA HEALTH BOARDS

Although the Area Health Board Act has begun the restructuring of the N.Z. health system on the basis of the WHO global strategy for primary health care - Health for All by the Year 2000. the obstetricians who have a strong vested interest in maintaining the status quo and high tech childbirth still have a dominant role in decision making in the hospital sector.

Peter Dunne, then Parliamentary Undersecretary to the Minister of Health (Caygill) warned against the "fanaticism of the neo-fundamentalists" saying that the reorienting of health systems to focus on health promotion will not work successfully if it becomes captive to the more strident and dogmatic groups who seek health promotion as a convenient means to become involved in political campaigns. (Address to Family Medicine Training Programme, 4.12.87 in N.Z. Family Physician, Summer 1988)

In a submission to the Auckland Hospital Board, Oct 1988, addressing the positions of domiciliary midwives within the proposed area health board, Auckland domiciliary midwives argued to remain under the Department of Health (HDU) sector of the Board.

We pointed out that the DOH had been the initiator and supporter of the primary health care initiative and as a result of many years of experience in the community had developed a clearer focus than hospitals on current health priorities and the operations required to support these.

Hospitals, on the other hand, have had primary health care imposed on them. As providers of specialist medical services, they have political, social and economic stresses not experienced by district health officers who provide primary health care. (Fogg, TR, Wellington District Office, DOH, NZMJ 25.11.87) Their bureaucratic and heirarchical structure divorces them from the market so 'they cannot respond easily to change in public demand' they react by closing facilities and reducing services rather than making other cost economies. (C. Terry, NBR 19.9.86) Or as we have recently seen, employing more highly paid managers or providing 16 reclining lounge chairs for short term blood donors (NZH 28.12.90)

The WHO Expert Committee on the Role of Hospitals at the First Referral Level (No 744, 1987) says, 'Hospitals are powerful, influential and long-established - and hence intrinsically resistant to change..' It saw a need for managers to change as much as rank and file and suggested 'changes in the recruitment of managers, and in their training, terms of appointment and performance appraisal'. (Ref below, p 71)

"Those who work in hospitals tend to be insular and isolationist in their attitudes to other forms of health care provision that exist outside their institutions and to regard them as of lesser quality than those with which they themselves are concerned". (Paine & Tjam, Hospitals & the health care revolution, WHO, 1988)

This booklet points to the inherent differences between hospitals and primary health care in relation to history, philosophy and style - hospitals actively focus on individual, sophisticated technologies and intensive treatment which "requires professional control and dependence of the patient on the provider".

At the primary health care level, activity focuses on populations as well as individuals, and simple methods of treatment and prevention and is generally slower in pace, people are required to be self-reliant, less dependent on providers. (p 54)

CENTRALISATION

When the domiciliary midwives in North Harbout and Health West, in the course of restructuring, were placed under the supervision of those respective managers of maternity services, the Auckland domiciliary midwives protested that, since the Area Health Board Act is based on decentralisation, this move was a dangerous trend back to centralisation which would weaken the Board's primary health care plans.

In a submission to the Health Benefits Review, May 1986, the Auckland HBA took up the issue of decentralisation, pointing out that decentralisation is not possible while the maternity services continue towards complete medical control and regionalisation.

Rosenblatt asserted that regionalisation imposes 'a structure on the health care system which can disrupt services at the periphery, undermine the provision of primary health care and alienate patients.

At the NZCOM Conference, Helen Clark, then Minister of Health, said she saw midwives as a very important part of our primary health care services.

Any move to place domiciliary midwives under the supervision of hospital services will not only further reinforce the medicalisation of childbirth, it will medicalise domiciliary midwives and it will medicalise primary health care.

This bid of the hospital sector to take over domiciliary midwifery care is not an isolated N.Z. problem. It is part of the "worlwide revolution in birth care" according to Wagner who was outspoken in exposing the hidden power relations around which the struggle polarised - eg territorial struggles between obstetricians and GPs; obstetricians and midwives; midwives and nurses over who controls health care, i.e. women's bodies, their babies and information.

He said "In every country (even The Netherlands) a different battle is taking place and all of it is part of the 20th century witch-hunt because men are afraid of the power of women and this fear is nowhere better seen than in regard to midwifery".

In N.Z. the contention between midwives and nurses resulted in the formation of the N.Z. College of Midwives in 1988. Since then midwives have been reclaiming midwifery as opposed to being 'obstetric nurses' i.e. handmaidens to obstetricians.

Resisting the medicalised control of their births, the women of N.Z. formed the Homebirth Association in 1978. This organisation has grown from strength to strength and has gained considerable political clout,- as noted in Choices for Health Care (1986) "The ability...to make some headway against the medical establishment demonstrat4s their growing influence". (p 56)

The HBA opposes any move for the medical establishment/hospital services to take over (medicalise) the domiciliary midwifery services. In fact, it is the home birth movement that can claim the credit for the current moderation of attitudes towards birth in hospitals. The Cartwright Inquiry added the further dimention of legalising patient rights and informed consent.

In North America, where midwives and midwifery were totally suppressed, lay midwifery has become a strong political force. Lay midwives were accepted as members of ICM in 1984. Lay midwifery also has considerable strength in Australia, and it is not without its supporters in N.Z.; in fact, it waits in the wings - all it needs is a 'raison d'etre'. eg women resist medicalised control!

Furthermore, domiciliary midwives are already well integrated into the public health sector through their previous association with the PPHNs. In the Auckland area, Carol Petersen, now District Director of Nursing has a well established relationship with the domiciliary midwives. Carol is also the AAHB representative on the Auckland Domiciliary Midwives Standards Review Committee (DMSRC). These were established at the NZHBA Conference, 1988, to monitor the practice of domiciliary midwives. Each domiciliary midwife is required to present an annual written report of her year's work and a self-assessment to this Committee made up of four consumers and four health professionals. The consumers are nominated by the HBA; the health professionals are Carol Petersen, a domiciliary midwife, a GP practising home births (nominated by HBA) and a hospital-based midwife (nominated by NZCOM).