20051-5-013

WORKING PARTY ON AAHB CONTRACTS AND RELATED MATTERS.

24 Nov 1990

1. PURPOSE.

1.1. This community WP was set up 19.11.90 at the Maternity Services Consumer Council (MSCC) meeting in the Conference Room, National Women's Hospital, attended by 20+ women representing consumers from a number of organisations, midwives, student midwives and a GP.

Its purpose is to prepare a submission re:
1) contracts for midwives & GPs with AAHB for use of facilities;
2) establishment of a Maternity Services Committee - currently referred to as a 'Review Committee' - its role, membership, power and relationship to Obstetrics Standards Review Committee (OSRC) and Domiciliary Midwives Standards Review Committee (DMSRC).

1.2. Formation of this WP resulted from conflict within the 'steering group' or working party set up 29.10.90 at a meeting of selected health professionals * organised by A.Nightingale & S.Denny, Managers of maternity services at NWH and North Hbr respectively. Here, on the suggestion of AAHB lawyer P.Moran the group agreed to become a working party to establish a contract.

The maternity service managers are seen by the MSCC Planning Group as being responsible for setting up a steering group to review contracts. The MSCC began as a Service Development Group (SDG) which boards are required to establish under S 29 of the Area Health Board Act, 1983: "to advise the board in accordance with any policy directive prescribed by the board, on the full range of health services in the public, private and voluntary sectors, relevant to its district".

2. CONTRACTS - CURRENT STATUS.

2.1. GP contracts with the AAHB are negotiated on the 'advice' of the OSRC which was established in 1979 by the N.Z.Medical Association Council "to present precise proposals for the establishment and monitoring of obstetric standards in New Zealand". (Appendix 1)

The Board provides the resources - buildings, bed, facilities and staff.

The Board is legally responsible as soon as a woman enters a board institution; it is also responsible for the service and is required under the Area Health Board Act, S 38 to establish quality assurance programmes..

2.2. Currently, medical practitioners have the use of these resources but are not subject to any Board disciplinary procedures. According to AAHB lawyer (Moran) new contracts have to "specify a chain of responsibility". They also have to include necessary mechanisms to enforce disciplinary procedures.

* Maternity service managers: A.Nightingale, S Denny, S.Haigh & H.Thompson; Prof Colin Mantell, Dr.T.Baird, Dr P.Rushmer, P. Moran, M. Hunter (NZCOM), J. Donley.

2.3. Aside from the lack of disciplinary mechanisms, the focus of health services is changing from centralised to decentralised, based on the concept of promoting health. This is the object of the Area Health Board Act.

2.4. The Nurses Amendment Act 1990 amended S. 49(1) of the Area Health Board Act to enable midwives to have access to area health board facilities on the same terms as medical practitioners.

This, then requires a contract which will overcome past anomalies and take into consideration future trends while allowing 'appropriate practice without undue constraints but protects Board staff and resources and has the necessary mechanisms to enforce the Board's disciplinary procedures'. (1)

2.3. Domiciliary midwives (DMs) are quite willing to comply with the Board's quality assurance programmes and disciplinary procedures.

They are however, not prepared to have their contracts granted on the 'advice' of the OSRC. As pointed out in a letter 30.6.89 "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". (2)

3. HISTORICAL BACKGROUND.

3.1. Historically and globally the obstetric profession has taken control of childbirth by blurring the demarcation between 'normal' and 'abnormal'. According to William Arney, 'Power & the Profession of Obstetrics', this profession 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. (3)

3.2. Since the 1950s the mechanistic approach to medicine (and childbirth) based on one process, has gradually given way to the ecological one based on a set of processes. The adaptation of management to keep a set of processes on course has made treatment systems, in general, more precise, more rapid and more 'humanistic', but it has also provided an "infinitely more effective means of control". (4)

'Monitoring', according to Arney is the new order of social control. "Monitoring and surveillance of every aspect of birth, of environment surrounding birth replaced the classic intervention in pregnancy, creating a new order of obstetric control". (5)

3.3. The New Zealand obstetric protocols are based on these concepts and development. In practice, the medical model of childbirth with increasing reliance on technology became the norm, but made decision-making more complicated and difficult. Again, according to Arney, a difficult decision 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. (6)

The Obstetrics Standards Review Committee is such a group.

4. NEW CONCEPTS.

4.1. Today, revolutionary changes are taking place in health care systems. These are based on the WHO concept of Health for All by the Year 2000, i.e. primary health care.

Primary health care is about decentralising health services, placing them in the community with community involvement and encouraging people to take responsibility for their own health status.

4.2. The concept of primary health care is not new. It was mooted as far back as 1937 when the Health Organization of the League of Nations said that the key to better quality of life and health was provision of better, decentralised health services which local communities would accept because they had been involved in deciding the form and content of their organisation. (7)

Primary health care was officially adopted by WHO in 1975 at the 28th World Health Assembly. Also, in 1975, Dr Halfdan Mahler, Director-General of WHO wrote in the Lancet (8) 'that when a specialised group is formed to perform certain actions, it is evaluated and continues to be supported because of the number of such actions which it does, rather than by whether a problem is solved'. He also said that the medical technology approach very much determined the shape of the health systems.

4.3. Global initiatives to change this type of health system began with the Declaration of Alma-Ata, 1978, followed by the Ottawa Charter 1984.

The global economic crisis/diminishing resources has now made these changes imperative.

5. NEW ZEALAND PRIMARY HEALTH CARE INITIATIVES.

5.1. New Zealand has responded to the WHO primary health care initiatives:

1983 - Area Health Board Act;

1990 - AAHB Principles of the Auckland Maternity Services begins with:

'Pregnancy and childbirth are natural life processes which will be protected and enhanced by skilled health workers in cooperation with the mother and chosen support people'.

It ends with 'a quality service is maintained and developed through an ongoing monitoring process which involves consumers and service providers and this process will be a feature of the Maternity Service.'

1989/90 Department of Health 'Discussion Paper for Care for Pregnancy and Childbirth' says, under, Philosophy:

Pregnancy and childbirth are part of the normal life experience of women. The majority of women have the ability to conceive, undergo pregnancy, give birth and breast feed without problems....

The role of the health professional is to share skills and knowledge, to provide information and support for

the woman. The health professional must respond to the wishes and choices of the pregnant woman and be committed to providing preventive health measures and appropriate care in response to these choices.

5.2. This is the first time since 1922 that the Department of Health has officially and publicly proclaimed that birth is normal! Such a conceptual change must result in changes in practice, in the long term.

In the short term there is resistance to change.
The OSRC wants to retain its 'advisory' powers. It is agreeable to exercise this power through a Maternity Services Review Committee made up of seven health professionals plus 'two lay people nominated by the National Council of Women'.

5.3. The AAHB Strategic Plan for Maternity Services recommended that a Maternity Services Review Committee which includes adequate representation from the community, be established.

That the purpose of the Committee be:
- to monitor the practice of all professional providers;
- to issue contracts with the Board according to established criteria. (9)

5.4. This recommendation evolved without sufficient debate from the recommendation from the Department of Health WP (7th draft) that Obstetric Standards Review Committees should be disbanded.

OSRCs, or any committee based on these concepts are relics of the past and are not appropriate to primary health care philosophy or practice.

Neither is it appropriate for such a committee to issue contracts In view of Section 2 contracts should be negotiated directly with the Board on predetermined criteria.

5.5. The Department of Health WP recommended that area health boards establish a Childbirth Services Co-ordinating Committee to co-ordinate pregnancy and childbirth services and to ensure the establishment of childbirth quality assurance programmes.

Such a committee would certainly have a role in recommendning criteria for contracts, i.e. basic qualifications & experience; evidence of indemnity insurance, term of contract & renewal etc.

6. QUALITY ASSURANCE.

6.1. The WHO document, 'Quality Assessment & Assurance in Primary Health Care' (10) states that quality in health care concern the degree to which the resources or services correspond to specific standards.

It also warns that the concept of quality, its assessment and assurance originated mainly in the world of clinical medicine, in hospitals, in industrial countries.

In primary health care, the information sought must be different and realistic. In the area of maternity care this would cover antenatal clinical care and education in relation to its accessibility and acceptability; labour and delivery care in relation to sufficient midwifery staff, adequate support in labour, continuity of care and back-up services for community

care; postnatal care in relation to consistent advice, establishment and maintenance of breast feeding, and for early discharge mothers, home care midwifery supervision and home help.

6.2. Another important point to consider is, What is a standard?

According to David Stewart (11) the first step in establishing a standard is to decide what "ought to be"; the next step is to determine the "principles, models or measures" that would lead to the achievement of that "ideal". If the wrong ideal is chosen, then the principles, models and measures to achieve that goal will also be wrong.

Standards, he says, are primarily a political issue and in the final analysis is anything agreed upon by those with the power to enforce it. "Standards set by professionals are often designed to assure the future security of demand for their services, as well as to assure their financial and political advantage".

6.3. AAHB is working on its quality assurance programme to develop a "policy and reporting structure which will embrace "quality of service" in its widest sense including consideration of: appropriateness, equity, accessibility, effectiveness, acceptability, and efficiency." (12)

A board-wide disciplinary procedure has been established ; NWH has a complaints procedure in place plus a patient advocate.

The NWH computer system is expected to be in operation early in 1991. This will provide an audit system for individual practitioners, revealing their complication rates with performance indicators.

Midwives, through their Collge, have developed and published Standards of Practice, Service and Education which are applicable to midwives wherever they work.

Midwives are subject to disciplinary action through the Nursing Council; doctors are subject to disciplinary procedures through the Medical Council.

6.4. In the community, the recent Department of Health contracts for doctors incorporates progressively introduced quality assurance programmes. (Appendix 2)

6.5. The DMs established their own regional monitoring systems - the Domiciliary Midwives Standards Review Committee (DMSRC). and this was endorsed at the National Homebirth Conference, Wellington, 1988. The committee is comprised of four consumers and four health professionals *.

Each year, every DM is required to present a written report to the committee which outlines and assesses her year's work, plus a self-evaluation.

The establishment of these DMSRC throughout New Zealand are in harmony with the principles of primary health care; with the WHO recommendations that women have the "right" to a central role in the determination and evaluation of their maternity care; and with the Cartwright recommendations on patients' rights based on informed consent.

* The PPHN who, as agent for the Medical Officer of Health was responsible for suprevision of midwives outside hospitals (before repeal of S. 58 of the Nurses Act, 1977); one DM; one GP involved in home births and one hospital midwife.

7. FINALLY!

7.1. Based on discussion throughout three WPs which had no specific terms of reference (and no consumers), a 19-item draft contract was presented for discussion on 19.11.90. Due to the 'internal conflict' as to whether this ad hoc WP was an 'in committee' one or not, these items were not dealt with.

A slightly edited version of the draft follows:

A. Contract: A regional one between the General Manager & the practitioner; term 5 years; determination of minimum qualifications & experience; to be negotiated through the MSRC.

B. Elements: Place of work - 1 or 2 primary with mechanism to deliver elsewhere;

- Specified availability - time/distance, cover;
- Clinical responsibility re booking criteria, appropriate place for delivery, referral, adherence to local policy and protocols;
- Accountability - to whom, how enforced, use of resources, meeting standards;
- Functions of management re communication, feedback, problem solving;
- Health promotion - preventive maternity care, role in wider health promotion;
- Research & review;
- Responsibilities for training & professional development of other staff;
- Medical audit;
- Career development & continuing education;
- Major outputs expected;
- Use of other staff - resident medical, nursing?, (midwifery), clerical;
- Cover for leave & sickness;
- Remuneration & other matters eg parking;
- Indemnity insurance (ambulance cover).

7.2. This sets out the basic contractural requirements and focus, but it obviously encompasses more than contracts for non-board employees for access to board facilities.

AAHB lawyer opposed the spread of the Board's role beyond the contract as it would be too difficult to monitor.

7.3 On the basis of this background information I would appreciate it if WP members would come prepared to make positive and concrete recommendations for a contract with reference to applicable items on the above draft; and the role/membership of a Maternity Service (Coordinating) Committee.

While a contract is fairly basic, our function is to place the contract in the context of whom the maternity service should primarily serve - mothers and their babies or health professionals. Hence, it is important to be clear about the role of the ? Committee.

8. REFERENCES:

1) WP 5.11.90
2) DMs reply to OSRC
3) University of Chicago Press, 1982, pp 51 & 54
4) Ibid pp 88/89
5) Ibid p 94
6) Ibid p 34
7) Paine & Siem Tjan, Hospitals & the Health Care Revolution, WHO 1988 p 31.
8) Lancet, Health - a demystification of medical technology 1975, 2: 829-833.
9) Education & Training in Maternity Services 5.4 & 5.5
10) Roemer & Montoya-Aquilar, WHO Offset Publication no 105, 1988.
11) David Stewart, PhD, Five Standards for Safe Childbearing, NAPSAC, 1981, chapter 3.
12) Annual Operating Plan 1990/91, draft 31/5/90 p27.

WP MEETING

Friday, 30 November, 1900 hours

at 3 Hendon Ave, Mt Albert 887 759 J.D.

Please - a volunteer to take 'minutes'. Thanks.

MEMBERS OF THE WP

Anne Becker	student	788 777
Louisa Brant	student	602 292
Anne Clark	consumer	894 462
Jilleen Cole	tutor	4159 257
Joan Donley	DM	887 759
Jackie Gunn	tutor	673 970
Barbara Harvey	mw	818 5629
Di Nash	gp	303 4639
Brigit Morison	consumer	....
Debbie Payne	consumer	864 794
Sheryl Robertson	consumer	838 6016
Carolyn Young	DM	836 2270

:NZMA - AK Division APPENDIX - C. 1

EDITORIAL NEWSLETTER - June 1980

THE O.S.R.C. - MORE THAN ANOTHER SET OF INITIALS ?

Like it or not, peer review is here again.

The Obstetric Standards Review Committee (O.S.R.C.), which was formed in accordance with a resolution of the N.Z.M.A. Council in April 1979, has had two meetings and has produced a Report.

Currently the members of the Committee are :-

Dr. B.G. Jew	New Zealand Medical Association (Acting Chairman)
Professor D.G. Bonham	Professor of Obstetrics & Gynaecology, University of Auckland
Professor R.J. Seddon	Professor of Obstetrics & Gynaecology, University of Otago
Dr. B.J.H. Insull	Royal College of Obstreticians & Gynaecologists
Dr. B.M. Williams	New Zealand Obstetrical and Gynaecological Society
Dr. M. McKerr	Royal New Zealand College of General Practitioners (Attendance at 2nd meeting only)
Mrs. Sandra J. Davies	Secretary.

The O.S.R.C. was formed "to present precise proposals for the establishment and monitoring of obstetric standards in New Zealand". To many practitioners, this statement will conjure up memories of Department of Health attempts to impose an Obstetric List upon unwilling obstetricians.

Obstetrics is vulnerable to increased control by the Department of Health because of the separate Maternity Benefit Scheme and the exceptional right to private practice in public hospitals. Departmental officials were involved in discussions with N.Z.M.A. Executive Committee of Council prior to the formation of the O.S.R.C. so perhaps we are faced again with another "increase in bureaucratic organisation" (H.V. Coop Newsletter No. 172) and a further loss of independence.

Despite the beginnings of the O.S.R.C., I believe that it is a step in the right direction. At present, it is an independent body whose report resounds with statements like "..... with the patient's interests paramount",....." criteria established by the Committee not by the Department of Health", "acceptable standards of obstetric practice", ".... the level of training .... should be determined by the Committee ... NOT by the Department of Health". (Report's emphasis). Laudably, the O.S.R.C. has divested itself of potential power by favouring the establishment of Local Obstetric Review Committees although it would retain overall responsibility for ensuring uniformity of standards.

Local committees, the O.S.R.C. recommends, should be established by Hospital Boards and would comprise the local Hospital Board's Obstetric Advisor, the poediatric Advisor and two General Practitioners who are in active obstetric practice. They would have two principal roles :

1. to ratify new contracts and 2. to review existing contracts.

The new contracts would require six months postgraduate training in obstetrics in a recognised hospital and would normally be valid for five years. Practitioners who have contracts already "should be permitted to continue working in terms of the contract or until the practitioner seeks a new contract" but the O.S.R.C. believes that existing contracts should be terminated after three years and new contracts substituted, with review at five yearly intervals.

The recommendation that the Local Committees be established by Hospital Boards is a weak point, not only because Hospital Boards are dependent on Central Government for finance and policy but also because a lot of antenatal care and an increasing number of births are taking place outside Hospital Board institutions.

There are other objections that one might raise but the O.S.R.C. report contains much to praise. So far the Committee itself has not been defined formally nor has it been accepted by anyone as the committee responsible for administration of Obstetric Standards. However, its message is clear - the establishment of standards of practice and methods of peer review is underway and will be imposed upon us unless we take action ourselves.

Despite the Orwellian ring, "peer review" is an illdefined concept that can take many forms. There has always been peer review, mostly of a nebulous character but now a more formal type is required and we have the opportunity to determine our own form, free from bureaucratic control.

The Obstetric Standards Review Committee has given a lead which we should grasp and upon which we should act.

M.A.H. BAIRD.

QUALITY ASSURANCE

APPENDIX 2

It is important that primary care services, along with other health services, are responsive to client's needs and provide a service which clients can be confident is of the highest quality. The medical profession already has a charter of general practice and a code of ethics which accepts that clients have a right to certain expectations of their general practitioners. As part of the new primary care policy, the government is working to have these expectations widened slightly to incorporate participation in quality assurance (QA) programmes. This move is consistent with the direction already being taken by both the Royal NZ College of General Practitioners and the NZ Medical Association.

Quality assurance programmes will be introduced progressively over the next year. The RNZCGP and the Department of Health are developing a range of QA modules from which general practitioners will be free to select those modules that are most appropriate to their practice. General practitioners will be involved in discussion about the details of the modules to be introduced.

Examples of Quality Assurance modules

* Record Review - review of a sample of patient records for presence or absence of information agreed to be expected in a patient record (e.g. sex, occupation, family history, personal history, smoking history, blood pressure, etc). This would be carried out by the participating GP and used as the basis for improving records within the practice.

* Patient Satisfaction Studies - A sample of patients from the practice would be asked their views on the practice and how the services might be improved.

* Attendance at Continuing Medical Education Meetings - Attendance at an agreed minimum number of hours of appropriate courses. Documentation of attendance and a critical appraisal of the courses or completion of an in-course assessment would be needed.

* Participation in Triadic Learning Process (Continuing Education) - A process of self-directed learning, in which the learner in consultation with a mentor decides their learning needs, how best to meet these and how to assess attainment of them. An assessor is involved in advising whether the learning goals and method of assessment are appropriate and realistic.

* FMTP Accreditation by QA process - Assessment for accreditation or re-accreditation as a teacher for the Family Medicine Training Programme would constitute participation in an approved QA programme.

* Peer Review Group Participation - This would involve the GP in participation in peer group discussions. A log of attendance and a self-report of participation within the group, as well as critical appraisal of how group participation affected the practice would be the sort of reporting required.

* Consultation Diary and Essay -
  (i) An agreed number of doctor-client contacts would be recorded to provide an indication of the usual type of practice. This would constitute the consultation diary.
  (ii) A clinical essay would be based on the diary (not a statistical analysis of cases). This might be a description of the practitioner's particular medical interests which might be demonstrated by the consultation diary. The essay should provide insight into the general practitioner's style of practice.

* Practice Visit - Practice visits might include observation of clinical work as well as assessment and feedback on the functioning of the practice. These would normally be carried out between general practitioners although some other models of practice visiting (e.g. including practice nurses or consumers to evaluate the practice more widely) may be of interest to some participants.

* Practice Plan and Annual Report - Submission of a strategic plan for the practice and practice goals and objectives in relation to standards of care and patient outcomes, plus a report on the achievement of these goals and targets would constitute a QA programme for a general practice.

* Targets in Health Promotion and Disease Prevention - Submission of goals and targets in health promotion for the practice for the year and a report on achievement of these would constitute a QA programme.

* Audit of Work - A detailed study by the practitioner or others of aspects of the practice (e.g. management of common or high cost or "tracer" conditioners, prescribing patterns, management of particular population groups) would constitute QA for the practitioners involved.

* Attaining Exams or Diplomas Relevant to General Practice - This could include:
  a) RNZCGP Part I
  b) RNZCGP Part II
  c) Diploma course such as Dip.Obs.
  d) Recognised distance learning module appropriate to general practice
  e) Other approved exams or courses appropriate to general practice

* Participation in General Practice Research - Submission of the full research proposal and a six-monthly report on progress in research relevant to general practice would constitute QA for the participating practitioner.

* Publication of General Practice Material - Publication in peer-reviewed publications of studies, articles or other writings relevant to general practice would constitute part or all of a QA module.