SAVE THE MIDWIVES

24

Spring 1990

CONTENTS

1990: A MEMORABLE YEAR

It would be difficult trying to pack anymore into what has been a momentous time of change with its associated need for continuous letter writing, lobbying and working on submissions. And just when you thought you never wanted to set eyes on another piece of legislation or write another submission, the **Health Commissioner Bill** has finally made it into the House so All of you MUST get writing again. Once the election is over, the Select Committees (SC) will be set up again, and the Social Services SC will be receiving submissions on this issue. This is a particularly important Bill and needs strong support.

The role of **Helen Clark** as Minister of Health in successfully bringing about changes for midwives practice and enabling DE midwifery training to take place in NZ must be acknowledged. She recognises that pregnancy & birth is a normal physiological process & has an obvious committment to both the profession of midwifery, and the need for women to have more choice and increased options. Women have achieved a great deal from her input into health.

Review of the Nurses Act is the next step. Because the Act in its present form is confusing, ambiguous & fraught with all sorts of difficulties, the Health Dept. has recommended it have priority status in the next Parliamentary session. Labour has supported this, but Nationals committment to such priority status is uncertain, so if there is a change of Government..... lots of letters need to be written and MPs spoken to, to ensure the Review retains its priority status.

Although the College of Midwives now have a representative on the **Nursing Council** (Karen Guilliland), there is a need for a substantial review of how the Nursing Council (NC) operates and whether it is appropriate for the NC to make decisions affecting the profession of midwifery. This is one of the issues that will be dealt with in the Review of the Act.

The COM National Conference in Dunedin was a real highlight with the role and practice of midwives being strongly affirmed. **Marsden Wagner** from the WHO pointed out that the technology of birth is often a reflection of that society's view of birth. In the light of the NZ statistics, this is obviously something that requires urgent attention. As well as needed changes in community attitudes, there needs to be a shift from the medical model where the pressure is "Don't stand there, do something" to the social model of "Stand there, don't do anything (unless necessary)".

Direct Entry proposals from Auckland and Wellington Techs. are presently before the Nursing Council awaiting approval. Otago & Rotorua are also planning DEM courses and the first courses are expected to be underway in 1991.

Judi Strid

Law change heralds new era in childbirth

AUCKLAND STAR 7-9-90

By JOSEPHINE GALLAGHER

Mothers-to-be can look forward to a new era in childbirth in New Zealand.

For the first time in 11 years, women have the choice of being cared for during pregnancy and labour by midwife alone — without a doctor having to be on hand.

Amendments to the Nurses Act which make the change possible have won parliamentary approval.

A spin-off could be the setting up of the country's first direct-entry midwifery course.

Midwives must currently train as nurses, despite a drastic shortage throughout the country.

Carrington Polytechnic nursing tutor Jilleen Cole, who has 20 years' midwifery experience, was part of a team which spent three years working towards such a course.

A Save The Midwives Association task force proposed a three-year, direct-entry, full-time course which, with the necessary approval, could start next year.

It was endorsed by the New Zealand College of Midwives which started two years ago.

The course would aim to produce midwives to the World Health Organisation definition.

The WHO says: "A midwife is a person qualified to practise midwifery, trained to give the necessary care and advice to women during pregnancy, labour and the post-natal period, to conduct normal deliveries on her own responsibility and to care for the newly born infant.

"At all times she must be able to recognise the warning signs of abnormal or potentially abnormal conditions which would require referral to a doctor, and to carry out emergency measures in the absence of a doctor."

In June, Carrington Polytechnic's Health Studies Department submitted the course to the Nursing Council for approval as an experimental programme.

But the council, which administers the Nurses Act, turned it down, saying under the act only hospital-based courses were allowed as experiments.

The College of Midwives approached Health Minister Helen Clark over the council's decision in the hope changes could be made to the Nurses Act to allow for the course. The minister previously lent her strong support.

The changes allow for direct-entry midwifery to be run at tertiary institutions, putting direct-entry midwives on a par with other registered midwives. Carrington Polytechnic has now asked the Nursing Council to reconsider its decision. It is expected to consider the issue early next month.

In 1979, the law was changed to require people wanting to be midwives to have at least three years' nursing training before midwifery education.

The task force believes the changes have been brought about because of increasing medical intervention and technology in childbirth.

This has led to increased demand for childbirth to return to being a natural process.

Auckland midwife and task force member Joan Donley believes, given support and patience, 85% of women can give birth normally and naturally.

A WHO maternal and child health specialist, Marsden Wagner, who visited New Zealand several weeks ago to attend the College of Midwives' conference, criticised the level of medical intervention in this country.

The use of drugs and caesarian sections was among the highest in the world, he said.

Mrs Cole added: "There is an increasing demand by women for greater choice in childbirth.

"People are seeing childbirth as part of the normal growth and development of women."

At the same time, she said, there was a growing number of women wanting to commit themselves to three years' training to qualify as midwives but many did not want to be nurses.

About 120 had shown interest in the proposed Carrington course.

Many had been waiting years for a course and were prepared to leave their homes from as far away as Invercargill to train.

"Midwifery and nursing are separate. They share some of the same knowledge and skills but are still different professions."

NZ Medical Association
NEWSLETTER
JUNE 1990

This year's great debate?

The role of the midwife

The debate about autonomy for midwives has begun.

If the Australian experience is an indicator, it may rage with an intensity second only to the abortion issue - which could seem an irony. The shared background is of course, "women's rights".

Health Minister Helen Clark says the Nurses Amendment Bill aims to give every woman free choice in deciding from whom she should seek obstetric care. She predicts that greater autonomy for midwives will see an increase in home births.

Almost 100 groups, including NZMA, made submissions to the Select Committee which reported back to the House at the end of May.

NZMA has no quarrel with the concept of greater independence for midwives. Yet some of the submissions, and some aspects of the Bill lead us to question whether "autonomy" may in fact, mean "isolation". That concerns us. We believe the team approach is still the ideal for good obstetric care, with GP, midwife, practice nurse, and obstetrician able to contribute their skills when necessary.

Of even greater concern is the lack of back-up facilities in a home-birth emergency situation. Emergencies can and do happen, even in the most "normal" birth..

The changes enacted by the Bill constitute a national health statement on the part of Government, yet there is absolutely no provision for back-up emergency services. There is, for example, no requirement that area health boards must provide "flying squads" or special units.

It is incredibly naive to imagine that hard-pressed area health boards will suddenly establish and run expensive obstetric, anaesthetic, nursing and telephone services for home-birth emergency, unless a contract requires this of them.

Without such services, no GP or even obstetrician, with twelve or twenty times the training of a midwife, would envy her the home birth environment.

The training available to New Zealand midwives is a 1000 hour (six-month) course. In the Netherlands, where midwives train for three years, they work autonomously, but within stringent conditions relating to back-up services.

New Zealand doctors working in the field of obstetrics have to meet tough requirements for review and recertification. No such requirements are made of the midwife. Yet she will be expected to cope, and may be encouraged to cope alone, because it is her "right to be autonomous."

She will also have the right to prescribe. Some of those making submissions would give her full prescribing rights. NZMA believes that given her limited pharmacology training, any prescribing rights must be limited to those drugs associated with normal pregnancy.

No-one could quarrel with the right of any woman to choose her caregiver, but Government has a duty to ensure that all the options are as safe as possible. We're not convinced that they are.

Major changes to the original Bill mean that NZMA has won the right to return to the Select Committee.

Lewis King

NURSES AMENDMENT ACT 1990

The Nurses Amendment Act 1990 enables midwives to provide all maternity services including delivery, for normal, pregnancies, without the supervision of a medical practitioner.

To ensure that the safety of mother and child is maintained, a number of other legislative amendments have been made.

The flow on effects from the legislation have major implications for a range of other health providers, in particular for pharmacists, benefits payment offices, pharmaceutical pricing offices, area health boards, medical laboratories and medical practitioners.

The legislation also has implications for the Nursing Council of New Zealand and for those involved in nurse/midwife education.

The Nursing Council is now able to investigate complaints against midwives in relation to the Social Security Act 1964.

The council is also being asked to consider giving approval for the establishment of a direct entry midwifery experimental course. That would mean that access to midwifery education would no longer be restricted to registered nurses.

In total five acts have been amended as a result of the new legislation, and a number of new regulations have been gazetted.

Registered midwives who are not registered nurses are legally not permitted to work in any other place other than an institution. This does not apply to any midwife who;

- immediately before 1 April 1984 was practising midwifery, in New Zealand, in any place other than an institution (Section 54 Nurses Act 1977).
- or to those registered as midwives under section 39 of the Nurses Act 1977.

The Nurses Amendment Act 1990 gives midwives autonomy and an extension of practice. This will impact on education and registration for beginning practice. It will also increase the need for learning opportunities for orienting practising midwives and those returning to the workforce.

The Nursing Council of New Zealand is now able to investigate complaints against midwives in relation to the Social Security Act 1964.

The Council, with the approval of the Minister, is able to approve experimental programmes in tertiary educational institutions.

That will allow the Council to consider approving the establishment a direct entry midwifery pilot course under Section 39 of the Nurses Act 1977. An amendment to Section 54 of the Nurses Act means direct entry midwives who qualify in courses registered under Section 39, can practise midwifery on the same basis as those midwives who are also registered nurses.

Access to Area Health Board Facilities

Area health board services provided to mothers under the care of a midwife are free.
Section 49(1) of the Area Health Boards Act 1983 has been amended to enable midwives to have access to area health board facilities.

Each midwife must, however, negotiate an agreement to do so with area health boards. Requirements for the agreement would be the same as those for medical practitioners.

Under such agreements midwives can arrange to admit women to public hospitals for maternity care.

Area health boards will, therefore, need to develop policy on agreements for midwives to access their facilities.

Choice of Service Options

Women can now choose to have childbirth services provided by a midwife only, a general practitioner, a specialist obstetrician, or a combination of health providers.

There are already a number of ways in which a midwife can provide maternity services, for instance through "domino" or "continuity of care" arrangements.

Reimbursement

Midwives now have a choice of options for reimbursement;

- They can be employed on salary by area health boards, with pay and conditions negotiated by the unions.
- They can be self employed on contract with area health boards, with pay and conditions negotiated between the two parties.
- They can choose to work in domiciliary practice in return for fees from the Department of Health. Eligibility is established through a contract with the Minister of Health which includes certain terms and conditions. These contracts come under section 110 of the Social Security Act 1964. The contract will continue to be administered by area health boards.
- Midwives can now choose to claim maternity benefits under section 111 of the Social Security Act. An option previously only available to medical practitioners.

The schedule of fees is now the same under section 110 and 111 of the Act.

The Social Security Act 1964 has been amended so that the scale of fees for maternity benefits may be fixed by agreement between the New Zealand Medical Association, the New Zealand College of Midwives and the Minister of Health.

The current maternity benefits schedule of fees was fixed by way of annual negotiation with representatives of the medical profession. As such, it applies to services wider than those provided by a midwife for a normal birth. The interpretation given as Part 2 of the fee schedule will not be altered until a new fee schedule is negotiated.

Conduct of labour and delivery fee will be for up to six hours, as determined in the domiciliary midwives fee schedule. Prolonged attendance fee will be payable when justified by medical reasons or other special circumstances. Attendances in excess of five for the care of a mother and baby in the puer perium will be subject to an explanatory note on the claim form.

A schedule of fees and the interpretation is being reprinted and will be forwarded to all midwives as soon as it is available.

The Department will convene a meeting between the interested parties to develop a more appropriate interpretation and fee schedule before the end of the year.

Prescribing

An amendment to the Medicines Act 1981 allows registered midwives to prescribe prescription medicines.

The Misuse of Drugs Act 1975 has also been amended. This allows midwives to prescribe, supply or administer pethidine - the only controlled drug which midwives can prescribe.

There is no defined list of medicines a midwife may prescribe, but the limits as to when a midwife can prescribe are set out in an amendment to Regulation 39 of the Medicines Regulations 1984.

It states that "No registered midwife shall prescribe any prescription of medicine otherwise than for antenatal, intrapartum, and postnatal care."

That means that it would be appropriate for a midwife to prescribe medicines such as iron tablets, antifungal agents, oxytocin, vitamin K, antacids and the controlled drug pethidine. Prescribing by midwives would not include the treatment of underlying medical conditions such as asthma or hypertension. It would also not include the prescribing of medicines such as antibiotics or oral contraceptives.

Nurses Act 1977

The Nurses Act has been amended to give women the choice of either a midwife or a medical practitioner for childbirth services.

In addition, the Act has been amended to provide for experimental programmes to be conducted at appropriate tertiary educational institutions.

Section 4 Membership of Council

The constitution of the Council was amended to take into account changes in health sector reforms. It provides for:

- the member who had to be an employee of the Department of Education is replaced by a member who is to be appointed on the nomination of the Minister of Education.
- the member who has to be the head of the nursing services of an area health board or hospital board is replaced by a member who is to be the most senior nurse employed by an area health board:
- the member who had to be a public health nurse employed by the Department of Health is replaced by a member who is to be a public health nurse employed by an area health board.
- the number of nurses nominated by the New Zealand Nurses Association has been reduced from six to five. The New Zealand College of Midwives now has the statutory right to nominate a person to the Council.

Section 42A - Functions of Council as to complaints under Social Security Act 1964.

This new section provides for the Nursing Council of New Zealand to investigate complaints against registered midwives in connection with the provision of maternity benefits or pharmaceutical benefits under Part II of the Social Security Act 1964. The new section is based on section 45 of the Medical Practitioners Act 1968.

Section 39 - Experimental programmes

This section has been amended to provide experimental programmes to be conducted at appropriate tertiary educational institutions. At present, programmes may be conducted only at schools of nursing that offer a complete nursing programme specified in the Nurses Regulations 1986. In practice this has limited section 39 programmes to hospital-based schools of nursing.

Section 54 - Offences relating to Obstetric Nursing

Section 54 removes the requirement that only a medical practitioner be responsible for a pregnant woman. It is now no longer an offence for a midwife to have sole responsibility for a pregnant woman.

Midwives registered under an experimental programme will now be able to practise midwifery on the same basis as other registered midwives.

ACTS AND REGULATIONS

may be obtained from the Government Bookshops at:

Housing Corp Building, 25 Rutland Street, Private Bag, Auckland, Phone 395-361 Telex: AUKPRNT NZ 60556

33 King Street, PO Box 857, Hamilton, Phone 70-639

Mercer Street, Private Bag, Wellington, Phone 711-783

Mulgrave Street, Private Bag, Wellington, Phone 737-320, Telex: govprnt NZ 31370

Centreprint, Cnr Queens Drive & Margaret Street, Lower Hutt, Phone: 698-533

159 Hereford Street, Private Bag, Christchurch, Phone 797-142, Telex: CRIPRNT NZ 4458

Shop 3, 279 Cuba Street, PO Box 1214, Palmerston North, Phone 74-585

Cargill House, 123 Princes Street, PO Box 1104, Dunedin, Phone: 788-294

LETTERS

Minister of Health

I am pleased to inform you that the Nurses Amendment Bill passed through the third and final readings in Parliament last week.

The amendments contained in the Bill enable a midwife and/or a medical practitioner to take responsibility for the care of a woman throughout her pregnancy, childbirth, and post natal period.

The implementation of the legislation should increase the choices available to women and their partners in childbirthing services. It restores autonomy to midwives, who were previously limited by the legislation which allowed medical practitioners only to take full responsibility for the care of the woman.

The amendment will also facilitate changes by those area health boards which are planning to make their services more flexible and consumer-responsive. It should also help boards to keep maternity services in smaller communities.

It became clear to me earlier this year that while the simple two clause Bill I had introduced was sufficient to bring about autonomy in principle, in practice further Acts and regulations would need to be amended if real autonomy was to result.

In removing the restrictions on the practice of midwifery, I believe that it is essential that the safety of the mother and child remain paramount. To be confident that safety will be maintained, and provide autonomy for midwives, consequential flow on amendments were made.

Midwives will be able to claim maternity and pharmaceutical benefits, prescribe pethidine, possess prescription medicines, and access area health boards on the same basis as general practitioners. The Nursing Council of New Zealand will be able to investigate complaints against midwives in relation to the Social Security Act.

Section 39 of the Nurses Act was also amended to enable the Nursing Council to approve experimental programmes in tertiary educational institutions.

The Nursing Council is being asked to consider establishing a direct entry midwifery pilot course under Section 39. An amendment has also been made to Section 54 of the Nurses Act, to enable direct entry midwives who qualify in courses registered under Section 39, to practise midwifery on the same basis as those midwives who currently have full registration.

I acknowledge that legislative change on its own does not necessarily bring about change. What is also required is a change in attitude on the part of health consumers and other health professionals, and a willingness on the part of area health boards to explore new ways of delivering services. I believe these changes will have a significant impact on the health and wellbeing of many New Zealanders, particularly women and their children. I look forward to seeing these developments.

Yours sincerely

Helen Clark
Minister of Health

Dear Editor,

As a long time advocate of direct entry midwifery training, having myself qualified through this route in England, I write to express my appreciation of the efforts of the New Zealand Save the Midwives group in their promotion of direct entry midwifery training. It is clear that midwives who are trained as such are safe and competent practitioners, and that the kind of midwifery they practise is that which women seek out. In recognition of this, England is rapidly expanding its pre registration midwifery programmes. Moves to legalise and to promote non-nurse midwives in Canada, the USA, and, now, in New Zealand, demonstrate the fact that the demand for such practitioners is international, despite the years of obscurity that midwifery has suffered in many countries. As a committed advocate of the training, and of the midwives it produces, I wish to congratulate the Direct Entry task force for the excellent outline curriculum they have produced, and for the tenacity they have shown in the promotion and development of the initiative. I look forward eagerly to hearing that the first intake of midwifery students has entered training. Women all over New Zealand will benefit from the eventual enactment of legislation allowing such courses to commence, and from participating in the programme which the task force have designed.

Yours sincerely,

Soo Downe
Derby
England

The Direct Entry Midwifery Task Force, New Zealand

We thank you for the opportunity of reviewing your report "Direct Entry to Midwifery" and we welcome the opportunity to comment on it.

We will begin by making clear that the World Health Organization sees midwifery as a separate and distinct independent health profession which, while of course collaborating closely with medical and nursing practitioners, should remain at all times an independent profession. I refer to the World Health Organization definition of midwifery which does not mention the profession of nursing. A very brief summary of the history of midwifery and nursing might help to clarify this situation.

Midwifery is an ancient profession and as long ago as 500 years, European countries were passing legislation for midwifery practice. As you know, the nursing profession began very much more recently and during the early years of the nursing profession, it was separate from midwifery and remained so until recently. During this century when the medical profession developed the specialty of obstetrics and began to compete with the midwives for the management of normal pregnancy and birth, the midwifery profession was unfortunately rather severely suppressed. During this period, in a few countries midwives came under the domain of the nursing profession. In a small handful of countries in the world today, midwifery remains under the nursing profession and all midwives must train first as nurses. It is most important, however, to point out that in the vast majority of countries in the world today, midwifery training is totally separate from nursing training and all midwives go direct into midwifery without having any previous training or experience in nursing. In all of these countries there is a separate Medical Practice Act, Nursing Practice Act and Midwifery Practice Act and the regulation of these three professions is handled completely separately. The United Kingdom was one of these few countries that went in the direction of a nurse/midwifery training and as a result there is a tendency for countries which are part of the British Commonwealth to also reflect this heritage.

It is also important to point out that in the UK today there is a strong resurgence of midwifery as a separate profession and the Royal College of Midwifery, which is separate from the Royal College of Nursing, has now made a strong move in the direction of direct entry training of midwives in the UK. This will then make the UK consistent with nearly all continental European countries and indeed the regulations for the European Common Market treat midwifery as a separate and distinct profession with its own separate direct entry training and its own separate laws and regulations for this profession. This new direction in the UK toward direct entry midwifery is also seen in other countries. For example, in the USA there is now the possibility for training both in nurse/midwifery and in direct entry midwifery and the trend in that country is gradually toward more direct entry midwifery. Canada has now just had the first legalization of the practice of midwifery in the province of Ontario and this province is presently developing training programmes in midwifery which will offer direct entry training.

In summary then, the international trend is strongly toward making a clear distinction between the separate professions of nursing and midwifery and a strong trend toward direct entry midwifery training. It would thus be a step forward in New Zealand to offer direct entry training for midwives and a step backwards to only having midwifery training for nurses. We recognize that such a progressive step as offering direct entry midwifery training would require some alteration to your legal mechanisms, but we believe that this would be an important step forward and that any necessary alterations would be definitely to the advantage of the health of the women of New Zealand. It is important to add here that in the few countries in which midwifery was temporarily under the aegis of nursing, there was a tendency for the nursing authorities to resist direct entry training and to insist that midwifery is a subspecialty of nursing. This position of the nursing profession has, for example, been seen both in the USA and in Canada. In both of these countries we have testified before legislative bodies indicating, as explained above, that midwifery is not a subspecialty of nursing, but its own, completely

separate discipline. In this regard, it has been argued that a woman who is trained first as a nurse and later as a midwife will have more options in her career. In actual practice, it has turned out rather to be the opposite. For example, in the UK many women interested basically in a career in nursing have gone on to get the degree in midwifery after they have completed the nurse training, not because they wished to practice midwifery but so that they could add this further training to their curriculum, in the hope of getting better positions in the future in the field of nursing. This has had the effect that as much as 20% of all women in the UK who have completed training in midwifery after completing training in nursing, are not practising midwifery and as a result it is a serious drain on the training of midwives in that country. This is particularly relevant in a country like New Zealand which urgently needs to expand the midwifery profession. A three-year direct entry course would facilitate this expansion and also facilitate more mature women entering the profession. It would also discourage women basically interested in a nursing career from taking training in midwifery when they never intend to practise midwifery. If New Zealand would wish to continue to offer also the possibility of midwifery training after nursing training, this would perhaps be appropriate since it would offer the most options for entry into the field of midwifery, but we certainly believe strongly that entry into midwifery should not be limited only to nurses.

We would also like to respond briefly to some of the more detailed considerations in your report. We believe that your training for midwifery in New Zealand should acknowledge more mature women, including those with child-birth experience, to enter midwifery. We also believe that training programmes in midwifery should encourage the training of midwives of diverse cultures, particularly in a country such as yours where there is a significant population of Maori and Pacific Island women. In encouraging more mature women and women from diverse cultures to train as midwives, the option of distance learning is an important one and should certainly be pursued. An effort should also be made to provide credit for previous experience and education. Here you can certainly draw on the experience of others. For example, in the USA a number of states, such as New Mexico, have detailed regulations for allowing credit for lay midwives and traditional birth attendants. I would urge that you contact the Midwife Alliance of North America to get information in this regard.

The majority of countries in the world which have direct entry training for midwives, provide a three-year cirriculum leading to a certification as a practising midwife. This is the pattern in continental Europe and the pattern which is being recommended by the European Common Market. Other countries also offer various options in addition to this option and we might favour multiple options. For example, in the UK there is now the possibility of a four-year course in midwifery leading to a Bachelor's degree as well as certification as a midwife. Such a course in Oxfordshire England offers a two-year preclinical training in which nurse students and the midwifery students are together. The last two years of clinical training are done separately leading to a Bachelor's degree in either nursing or midwifery. We feel that this is a very practical model in that it recognizes the common body of preclinical knowledge in nursing and midwifery such as, for example anatomy, but at the same time honours the fact that the practice of these two health professions is entirely separate.

We hope that the above comments will be of value to you in your important effort to establish a direct entry training in midwifery in New Zealand. Please let us know if there is anything further we can do.

Yours sincerely,

WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTE
WELTGESUNDHEITSORGANISATION
ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
REGIONAL OFFICE FOR EUROPE

Marsden G. Wagner
Responsible Officer, Maternal and
Child Health

What's on the "political agenda" ?

Parties release their policies for women

BOTH LABOUR and National released their policies on women last month.

Labour has issued a 10-point list of objectives, headed by the pledge to raise women's rates of pay through the implementation of pay equity and equal employment opportunity laws.

Other objectives include paid parental leave, specific training for women to increase job opportunities, and better access to health care.

A resource centre will be established to help eliminate sex role stereotyping and EEO programmes will be advanced in educational institutions.

Labour promises to increase the number of female government appointees by 25 per cent, and also to incorporate unpaid work done by women into the national accounts to establish the real value of women's role in society.

Childcare will be made available for every parent who seeks it, with more money for the early childhood sector.

Decision-making bodies will be required to give Maori women a voice.

Meanwhile National would repeal the Employment Equity Act and build an economy in which competition would foster a commitment to employment and pay on merit.

National would increase the penalty for rape, retain the Ministry of Women's Affairs and encourage women to develop new skills.

NZNA executive director Gay Williams said Labour's plan, if implemented, would continue to significantly improve the position of New Zealand women.

NZ Nursing Journal, September 1990

LABOUR

Helen Clark, Labour Health Minister

Don McKinnon, National

NLP NEWLABOUR PARTY

Maire Leadbeater, Health Spokesperson, NewLabour

The Greens official Logo

Stephen Rainbow, Green

1

What is your commitment to a publicly-funded, public health service and what is your position on the privatisation of services?

The Labour government is committed to retaining a publicly funded health system which is equally accessible to all New Zealanders. Health care should be provided on the basis of need, not ability to pay. The Social Security Act currently prohibits the privatisation of facilities in the public hospitals. That will remain the case under a Labour government. Area health boards are responsible for identifying the particular needs of regions and tailoring services to suit.

National will put in place structures to ensure public hospitals become more efficient. That is why the private health sector will be allowed to tender for public health work where appropriate. Public and private hospitals will be encouraged to subcontract out work if it is to their advantage.

NewLabour believes that health care should be free and universally available. We are totally opposed to the privatisation of the health service.

---

1. Greens remain committed to a publicly funded public health service which is available to all, and view with some concern the development of a dual health service providing more immediate attention for those with money. Health is a right which must not be denied to anyone because of their economic situation.

2

How will you deal with the staffing crisis facing our hospitals?

The Health Department monitors staffing and recommends action where necessary. The staffing of individual hospitals is the responsibility of area health boards. Staff shortages are often specific to particular specialties, individual boards, or institutions. While efforts must continue to overcome shortages where they exist, it is also important that other resources are managed effectively so that the staff time which is available is used most productively.

Under a National government, public hospitals will be given more autonomy in the management of their own affairs. Staffing levels will be dictated by hospital management and union arrangements.

The NewLabour budget has costed for a major increase in health funding to ensure that the staffing crisis is ended permanently. For example we would immediately inject $100 million into the public hospital system to redress the damage done by cuts in health spending.

---

2. Green priorities are care for people and care for the environment. Therefore resourcing health care would be a priority, both in terms of increased staffing levels and providing adequate resources for primary health care intitiatives by area health boards.

3

How do you intend area health boards to fully implement primary health care initiatives given the current shortage of funds in the health service?

The Labour government significantly increased resources available for primary health care in this year's Budget. The new primary health care in this year's budget. The new primary care subsidies will ensure that price is not a barrier to families receiving primary health care services.

Area health board grants increased by 5.6% this year. Some funds were tagged specifically for health goal initiatives for illness prevention.

Area health boards will be expected to represent patients and taxpayers. But I believe implementation of National's hospitals' policy will allow hospitals to respond to patient needs.

Primary health has priority for increased health spending. NewLabour would spend $200 million (the annual cost of keeping two frigates operational) to make all general practitioner visits free. We would abolish prescription charges.
Area health boards will be required to put more resources into community health and the diseases of poverty — resources will be allocated to where the need is greatest.

3-5. The Greens are a relatively new political organisation and so we do not have the kind of detailed policies which the established parties have. We do, however, wish to bring the influence of many people working in a variety of fields in ways which challenge existing values and behaviours,

4

What increase can we expect in health spending from the national budget over the next three years?

Health spending is likely to continue at around its current level. There will continue to be greater emphasis placed on primary care, health promotion, and illness prevention services.

Unfortunately a National government will not be able to increase spending on health in the short-term. Future budget increases will be determined by economic growth.

NewLabour has budgeted for an $340 million increase in health spending.

---

to bear on the political process. This applies in the area of health as much as anywhere.

The Greens approach health from a holistic point of view. We believe that health care should be based on the whole person, including their physical, emotional, intellectual and spiritual needs.

The individual's health

5

What is your position on enterprise bargaining in the health sector?

The Labour Relations Act now allows for enterprise bargaining in workplaces with 50 or more employees, where the majority of those employees agree.

National will allow employees to choose their own bargaining agents, be they union or otherwise, to represent them in industrial negotiations.

NewLabour will retain the national award system of wage determination.

---

cannot be separated from the effects of the physical and social environment of which they are a part.

Greens believe that preventative health care based in the community is to be preferred to high-tech (and therefore expensive) health care in large institutions.

6

What is your commitment to the implementation of employment equity issues?

Helen Clark, Labour Health Minister

The Employment Equity Act has been passed by this Labour government, and demonstrates the Labour Party's commitment to employment equity.

Don McKinnon, National

I am opposed to discrimination in the workplace.

Maire Leadbeater, Health Spokesperson, NewLabour

NewLabour will take immediate steps to implement pay equity in New Zealand. The Equal Pay Act will be replaced by legislation that will ensure that true pay equity is achieved within three years.

Stephen Rainbow, Green

6. The Greens are totally committed to equal employment opportunities (and to laws against discrimination in all fields).

7

What is your party's position on the right of unions to represent their members?

The Labour government has no intention of changing existing laws relating to either union membership or their rights to represent their membership.

National will reintroduce voluntary unionism to give New Zealanders the right to decide whether or not they want to join a union.

NewLabour supports the rights of trade unions to represent their members and to be the applicant party to disputes of interest. NewLabour recognises the right of unions to strike, picket or organise boycotts and take other forms of direct action.

7. Greens recognise the essential role of unions in the harsh economic environment which is now prevalent. We also recognise the choice which increasing numbers of people are taking to meet their needs in the complementary health sector, a development which we support. We would look to ways of giving more recognition to the complementary health sector and encouraging increased dialogue between its practitioners and the established health sector.

8

Are you committed to a national cervical screening programme funded centrally?

Yes. Funds have been allocated for it. Reduction of the death rate from cervical cancer is one of the ten health goals I have set as priorities for the health system over the next ten years.

Public hospitals will be given more autonomy in the management of their own affairs.

NewLabour is committed to a national cervical screening programme funded centrally.

The Greens would place much more emphasis on preventative health care, aiming to inform people from the earliest possible stage about healthy diets, exercise, stress management and emotional health. More emphasis should be put on health care in the workplace and schools, taking a proactive response to ensure people have choices about the way that they live and access to information

(continued next column)

9

What is your position on occupational deregulation?

Many aspects of existing occupational regulation need to be reviewed. The review of the Nurses' Act will be completed and new legislation put in place by the Labour government.

Jobs can be saved when workers are allowed to make arrangements to suit local conditions.

NewLabour will seek to break down the professional divisions between doctors, nurses and other health workers. However, we believe that there must be no loss of professional standards and we support the right and responsibility of professional associations and other peer review mechanisms to promote standards within professional groups. All personnel should be paid appropriately for the work undertaken so that, for example, if a nurse is asked to undertake a responsibility usually assumed by a doctor she should be rewarded accordingly.

about diet, stress management, contraception etc. The prevention of HIV/Aids is another area where improved resources need to be made available, as is a national cervical screening programme.

The New Zealand College of Midwives

NATIONAL CONFERENCE

WOMEN IN PARTNERSHIP

Joan Donley reports on the First National Conference of the New Zealand College of Midwives Inc (NZCOMI) held in Dunedin in August.

The theme "Women in Partnership" reflected the unity between midwives and the women we support during the pregnancy cycle. In fact the NZCOMI is the first professional body to include consumers, not only in its membership, but also in a decision-making capacity.

The conference was opened by Minister of Health, Helen Clark, who was made an honorary midwife in appreciation of her efforts in midwifing the Nurses Amendment Bill, which would restore autonomy to New Zealand midwives, through parliament.

Guest speaker Dr Marsden Wagner, World Health Organisation Regional Officer for Maternal and Child Health for the European region, made an impact on both the conference and the obstetricians he met with in Auckland, Wellington and Christchurch. The latter found him hard to handle, especially when he said, "You have far more interference in pregnancy than is necessary in this country."

He made reference to New Zealand's 14 percent rate of forceps deliveries, compared to 5.7 percent in European countries, excluding the UK. "Not only are you using forceps twice as often as you should, you are using the wrong instrument," he said. He pointed out that ventouse (vacuum) extraction is preferable as research shows that this method does less damage to the baby's head and to women.

Wagner was also critical of our 30-40 percent epidural rate. "Nowhere else in the world do I know of such extensive use of epidurals," he said, adding they "made women dead from the waist down" and contributed to out high rate of operative deliveries, which result in 25 percent of our babies being "either pulled out or cut out of their mothers". He also detailed the side effects of epidurals and pointed out that they are the second most common cause of women dying during child-birth in the UK.

Wagner does not support the routine use of ultrasound in pregnancy. Waiting for someone to discover harm rather than actively pursuing the issue of safety is not satisfactory, he said. He also felt there was a conflict of interest when the safety monitoring was done by the same clinicians who use it as part of pregnancy care. There is evidence that the intensity of ultra-sound pulses is extremely variable and the dose absorbed in one place is not predictable. There are no agreed standards for the equipment.

His outspoken criticisms were not designed to enhance Wagner's popularity with obstetricians. However, they were appreciated by those concerned about the high level of medicalisation of child-birth in New Zealand.

Each day of the conference was devoted to a specific topic: consumerism, midwifery and feminism – "the three greatest threats to modern obstetrics!" With midwifery autonomy in the pipeline, there was much discussion on how midwives would meet this challenge. Having been trained in hospitals, midwives, like women, have succumbed to the fear engendered by the medical model of childbirth, and been oppressed by the hierarchical structure which makes them the handmaidens of doctors. In struggling to free themselves from this fear and conditioning they also have to contend with those trying to prevent them from breaking free.

The only place a midwife can work with any real independence is in the community. However, there is a strong lobby to require midwives to work for two years in a hospital first. This is completely counter-productive! Those midwives competent to practice, as the Report of the Social Services Committee concluded, are those registered by the Nursing Council. This was endorsed at the conference.

Since 1988 training has been a post-graduate year for nurses. A midwifery option within the Advanced Diploma of Nursing still exists at Waikato and Christchurch Polytechnics, in spite of efforts to have this discontinued. The other contentious midwifery training issue is that of "direct entry" which allows women with no previous nursing experience tot rain as midwives. At present a possible three-year direct entry midwifery course at Carrington Polytech is blocked by lack of approval from the Nursing Council. The legal impediments have been removed, but the Nursing Council still has "philosphical problems" arising from its "misconception" that midwifery is a post-graduate course of nursing rather than a profession in its own right.

An amendment to the Nurses Act 1977 would allow direct entry midwives to practice midwifery on the same basis as other registered midwives. Also, they can now register as domiciliary midwives. But the National Council of Women also opposes direct entry as it has been suggested to them by "some people" (guess who?) that three years comprehensive nursing education are necessary to guarantee familiarity with all complications and abnormalities. Direct entry would ease our serious shortage of midwives and make midwifery training more available to Maori and Pacific Island women would can then provide culturally sensitive care for their own people.

With independence, midwives will be directly accountable for their practice, especially on the domiciliary scene. In view of the medical opposition to this independence we can expect a few "witch hunts" in an attempt to show that the only "safe" practice is medical practice.

As Wagner pointed out in several lectures "babies do die" regardless of the quality of attention. This is a fact of life. It is also a social problem. Although New Zealand has a "no fault" medical misadventure system embodied in the Accident Compensation Act, this term is not precisely defined. As independent practitioners midwives will be subject to actions to sue by parents who feel a child has been damaged due, as they see it, to mismanagement of the birth, and will need indemnity insurance.

Re-education of midwives, birthing women and their partners is also needed in recognising that pregnancy and birth are normal functions. Wagner pointed out that when women are "delivered" rather than "giving birth" they become dependent on doctors – both in the short and long term. For over 50 years New Zealand women have been conditioned to believe, and have also experienced, birth as a medical crisis. Therefore, many will see midwifery care as either dangerous or a second-best option.

However, for the first time since 1927, the Department of Health has officially claimed that birth is normal. In Policy Recommendations for Pregnancy and Childbirth (about to be published) it states that "pregnancy and childbirth are part of the life experience of women. The majority of women have the ability to conceive, undergo pregnancy and give birth without problems..." This official endorsement of birth as normal should help change the present attitude towards childbirth: midwifery independence will provide women with greater options. □

Too much interference during birth — doctor

OTAGO DAILY TIMES 20.8.90

By Barbara Fountain

Twenty-five percent of babies born in New Zealand last year were "pulled out" or "cut out" of their mothers.

Statistics such as these reveal the level of "medicalisation" of childbirth in New Zealand, according to the European office director of maternal and child health for the World Health Organisation, Dr Marsden Wagner (Copenhagen).

"You have far more interference in pregnancy than is necessary in this country," Dr Wagner said.

"Somewhere between 30 and 40% of all women during delivery in New Zealand are made dead from the waist down.

"Nowhere else in the world do I know of such extensive use of epidurals," he said.

The use of this form of pain relief meant the woman was no longer able to carry out her own pregnancy and forceps were needed to deliver the baby.

DAMAGE

The national rate of forcep delivery in 1989 was 14%, compared with 5-7% in some Western European countries.

The other part of the problem was that once the decision was made to pull a baby out 94% of the time forceps were used, and 6% of the time a vacuum machine was used.

These figures should be opposite, Dr Wagner said, as research had show forceps caused more damage to the baby's head and to the woman.

"Not only are you using forceps twice as often as you should but you are using the wrong instrument."

The WHO has stated epidurals should not be used solely for pain relief.

"They are the second most common cause of women dying during childbirth in Britain," Dr Wagner said.

Combining the rate of forcep delivery with that of caesarean delivery (11%) 25% of women in New Zealand were having their babies pulled out or cut out, Dr Wagner said.

At Christchurch Women's Hospital the rate was 37%, Wellington Women's Hospital 30% and National Women's Hospital in Auckland 27.8%.

These women were being subjected to all kinds of risks as well as being denied the experience of birth, Dr Wagner said.

The women could also be left with a feeling of "my body doesn't work", he said.

"The single most important thing to change all this is to put midwives in charge of all normal pregnancies and births," Dr Wagner said.

In the Netherlands more than 70% of all women had a midwife as the only birth attendant, there was never a physician in the room, and the country lost the fewest babies at birth.

Dr Wagner stressed these midwives were working in hospitals and were not a group of "hippy-like" women as some doctors in New Zealand sought to portray midwives.

Many of the problems in pregnancy started when drugs were given for pain relief, he said.

"The single most valuable pain relief is another woman there giving her whole support."

In New Zealand hospitals research has shown that every time shifts changed the pain relief usage went up.

If there was a system with continuity of care this was not a problem, Dr Wagner said.

"A whole generation of New Zealand women have been denied what their European counterparts take for granted."

"The young New Zealand family starting out in life get a very wanted pregnancy, take out money and pay for a private obstetrician because they believe it will give them a safe pregnancy. They are going to get into all this unnecessary management and it is going to cost them money that is thrown away.

"There is a whole generation of New Zealanders who truly believe this is the way it has to be done."

They had to be made to understand that midwifery was not second-class obstetrics, Dr Wagner said.

Control and power were the issues at the heart of the battle for pregnant women, he said.

Dr Wagner was in Dunedin for the annual conference of the New Zealand College of Midwives.

	New Zealand Operative Birth in percent (1989)			Mew Zealand Epidural rate in percent (1989)	
	C-Section	Operative vaginal	Total		
Home birth	3.7	1.4	5.1	0	
Wellington Women's	15.5	14.5	30.0	40.6	
Masterton	11.6			10.9	
Middlemore	8.8	5.4	14.2	20.0	
National Women's	15.7	12.1	27.8	30.0	
St Helens	13.8	12.3	26.1	29.0	(including elective c-section)
Waikato	14.9	11.0	25.9	25.0	
Taranaki area	13.5	9.0	22.5	9.0	
Hastings	8.4	23.0	31.4	22.5	
Napier	11.6	20.0	31.6	22.6	
Palmerston North	19.0	8.3	27.3	31.0	(including c-section)
Nelson	11.3	18.0	29.3		
Canterbury Women's	22.0	15.0	37.0	37.0	
Queen Mary	16.3	14.3	30.6	31.5	(19.9% for pain and 11.6% for operative birth)
Dannevirke	7.0	12.0	19.0	3.0	

MARSDEN WAGNER

WISE BIRTH OPTIONS

Speaking at a public forum in Auckland 13.8.1990

Marsden Wagner did his medical studies and his specialty training in Paediatrics in the USA. He then achieved an advance degree in Epidemiology and Public Health, spent time in research and teaching and became Director of Maternal and Child Health for the state of California. He moved to Denmark in 1971 to direct a Research Institute and since 1978 has been Regional Officer for Maternal and Child Health for the European Regional Office of the World Health Organisation. His special interest is in Reproductive Services and Child Health Services in Industrialised countries. He is also a single father of 4 children which he feels is a real achievement and something he is very proud of.

All men are outsiders when it comes to birth so he speaks as an outside observer. When talking to O&G's he asked them to imagine a rugby match where the players out on the field playing the game are the clinicians. At half time there is a meeting to discuss how to do better in the next half. The coach who hasn't played but has been watching and has an overview of the whole game leads the discussion. He's like the epidemiologist who looks at the overall perspective, and <u>together</u> they must plan for the second half. And where are the birthing women in all this? They are the ball being kicked around, but like the game, the focus should be on what is happening to the ball and not the players.

Nature of Pregnancy & Birth

Pregnancy is not an illness and birth is not a surgical event. However, in over 25% of births in NZ, birth is a surgical event. Birth should be a normal part of life, but this has been lost sight of by both Drs and the public.

He would like to hang a big sign BABIES DIE in the middle of Auckland to emphasise the reality that some babies die around the time of birth. We can reduce the incidence, but it will still happen.

In order for Drs to take over maternity care, they had to sell the idea that they were better than midwives, so they sold safety. They say - come to my hospital which you can have the benefit of my machinery and my expertise for the perfect baby. But this guarantee of a safe outcome has backfired as people demand to know what went wrong when the perfect baby doesn't arrive. If you play God, you have to accept the consequences!

He recalls very clearly the death of a baby due to a mistake in his judgement, but is very aware of the hostility from Drs when he mentions this, as this should not be spoken about. However, he feels it is important to say that Drs are human and they sometimes make mistakes that kill people.

Birth is a part of life, and you really have to twist it to make it fit into the medical scheme of things. NZ is not yet ready for home birth as a big part of maternity care, but he emphasised that women must have HB as an option.

Safety

He noted that the medical profession are still saying that home birth isn't safe and hospital is. However, there is no such thing as real safety as there is always the possibility of death.

NZ has a perinatal mortality rate of 8::1000

6 of these it wouldn't matter what you did the outcome would be fatal. 2 of them could have been prevented, but do you develop a maternity care system putting 994 women through the process to save 2 babies? This has been an arbitrary decision made by the medical profession without consultation with women.

Doctors Power

Drs aren't bad or evil, but the medical training system and the life experience of being a Dr does incredible things to your brain. He described the odd reactions to when he dropped the title of Dr and cited a personal experience of being given the run around when trying to get information about his dying father, and how this changed to instant attention when he said he was a Dr. He said you have to experience this sort of power to know how great it is and how hard it is not to end up with a Jehovah complex.

He has noted that in countries where midwifery is supressed, the medical profession literally sit and wait for a death at home and then target the midwife. This is particularly evident in Canada, the only country in the world with no legal midwifery system.

UK trained midwives are working there and when there was a big inquest following the death of a HB baby, the 10 midwives working in Toronto raised enough $ for an excellent woman criminal lawyer. Whilst researching the case, all the Drs she spoke to praised the performance of the midwife and said the baby would have died anyway, but not one Dr in the whole province of Ontario would testify, so Marsden came from Europe to testify for 6 hours.

Most of this time was spent educating the jury about midwifery so at the conclusion, the jury wrote a 10 page document demanding legalisation of midwifery!

So the whole business of safety is a way of bludgeoning women to suffer the indignities of hospitals. In NZ, women understand that this is part of what birth is all about. They accept that epidurals and other such procedures are safe because the Dr says so.

Turning Point for Change

Several things are responsible for the changes taking place. There is a global trend towards the resurgence of midwifery and our legislation change will reinforce this in NZ. Also, Obstetric technology is badly out of control. The form this takes varies with each country. For example, the USA c-section rate is 25% and in Brazil it is 33%. In Rio de Janeirom wher Drs sell the need for women to keep their vaginas honeymoon fresh, the rate is 90%!

NZ overall, with a 1987 caesarean rate of 11.2% is not too bad, although there is regional variation withsome hospitals like Canterbury Women's having an incidence of 22% that needs considerable reduction. However, our rates of operative vaginal deliveries are very high at 14% which is almost twice that of European countries which vary from 5-8%. Our second problem is that 94% of these deliveries use forceps and 6% vacuum extraction.

Medical Scientific literature clearly shows that when forceps are used as the first choice, morbidity increases and there is more risk to mother and baby. Using the figures from a forceps v's vacuum study published in the British Journal of O&G, he had worked out that in NZ with the continued use of forceps as the first choice of removal out of:-

58,000 births per year

14-15% are forceps which translates to 8,700 births

There will be-

2,100 unnecessary pudental blocks & other regional anaesthesia

1,700 women unnecessarily experiencing moderate-severe pain as a result of forceps

Over 900 women experiencing moderate-severe perineal trauma

Over 600 women will suffer severe pain for several days after

This is all just from forceps and requires URGENT attention.

Operative Birth In NZ

The combined caesarean section and forceps rate in NZ hospitals of 25-30% means that 1 in every 4 babies are either cut out or pulled out. This means increased risk of morbidity and mortality for the baby. C-section carries all kinds of risks and is a very serious procedure. It is one of the major causes of Respiratory Distress Syndrome (RDS) - the major cause of death in ICU babies.

NZ obstetrics is a child of UK obstetrics and the reason we do forceps instead of vacuum is due to the British Empire, but we are out doing them due to our high rate of induction and augmentation. Induction causes severe and painful contractions which increases pain and the need for analgesia and anaesthesia which inevitably leads to the need to drag the baby out.

All this interference has destroyed the natural system, messing it up so the medical system has to be used to drag out the baby. But women believe that epidurals are safe, so we have a generation of women who accept this practise as fine.

The System Is Failing Women

This also means that 1 in 4 NZ women are being given a very powerful message: that they are inadequate and can't give birth without this heavy duty assistance. This can affect the confidence the woman has in herself, the baby and her ability as a mother.

It also sets the stage for a life long dependency on the medical profession. These are not idle things we are talking about. In addition, all these techniques are very expensive. For example, just one epidural cannula is $240 and our very high 30% rate of epidural is shocking. At least half of these are for pain relief which is a practise the WHO strongly advises against.

Induction

He also expressed concern about induction conducted for convenience; known as daylight inductions. His suggestion to epidemiologists was to take all NZ birth certificates for a year and pull out by day of the week as overseas information has shown induction for convenience will show lower rates of birth at the weekend, and increased rates on Monday and Tuesday.

Epidurals

Induction is a very insidious procedure which sets off a well documented chain reaction of interference. Epidurals result in 5 times more forceps deliveries so considering our high usage of epidurals our forceps figures are not surprising. He suggested reading the insert from the epidural package regarding complications. There is a huge list affecting both mother and baby. Epidural babies come out blue.

In the UK, a confidential enquiry into maternal death brought in a special team of outside experts to study the cases. The Health department published the findings of the last enquiry into the preceding 3 years and the second most common cause of death was from epidurals. This is not an innocuous procedure and the rate in NZ is really shocking.

Women need to be told the risks so they don't expect to have one. They have been sold on the idea but must be told the truth.

Although there have been movements to challenge the continued inappropriate use of technology, the trend continues. In NZ small hospitals are being shut down despite data showing their safety. Training physicians differently and using more midwives are needed to change a maternity care system which is Dr controlled and becomming more and more centralised into bigger hospitals.

Fundamental attitudes in our society reinforce intervention. If anything is wrong the custom is to take a drug for it. Instead of looking at the cause and attempting to relieve it, people tend to take a pill instead.

Midwives are Safe

The 4 countries in the world with the best record of losing the fewest babies have midwives attending 70% of all births as the sole caregiver. They provide the care during pregnancy, at the birth, postnatally and are responsible for ordering the discharge. The woman never sees a Dr and there is never a Dr in the room.

The results are clear - midwifery is the safest profession to be attending normal pregnant and birthing women.

Rates of Intervention & Technology

- The stronger and more independent the midwifery profession is, the less intervention occurs.
- The greater the distance between women and O&G's - the less intervention.

In Helsinki, Finland a scientific random trial was conducted where: half the women were told to stay home in labour and not go to hospital until the last minute.
: the other half came into hospital at the usual time

Results showed that the group who stayed at home until the last minute, had half as much intervention. The morbidity and mortality rates had an identical outcome, but the rate of forceps, c-section and pain relief etc. were halved where the women stayed at home. This clearly showed that a way to prevent intervention was to stay out of hospital.

There is a funny kind of double standard in pregnancy. The medical profession will use something until it is proven dangerous, but on the other hand quite the opposite applies for natural methods. Women have to prove something is OK before they are allowed to use it! Water is a great alternative to pain relief that needs to be tried more often.

Solutions to the NZ problem

1. **Train more midwives and educate women about midwives**

In Germany, there is a law that states a midwife must be present at every birth wherever it takes place so women grow up knowing all about midwives. In Denmark each midwife takes an oath to attend any birth she is asked to. She can't say no unless she is sick or drunk, or she could lose her license.

It is tragic to have in NZ a generation or 2 who have lost this understanding of midwives. Midwives are a key element in the informal women's network of any community. The French translation of midwife is wise woman and the Danish jordmor means earth mother. In contrast, Obstetrician means to stand in front of and to confront.

Midwives must be the preferred person to attend births, as they have the best record of care.

2. **Free Standing Birth Centres**

This is worth considering. Take over a house in the neighbourhood and turn it into a centre run by midwives where women can go to give birth. They have a consultant O&G on call and the backup of a hospital for transfers. Women go to the centre for their prenatal care and the birth where they may stay up to 24hrs. They usually don't see a Dr at all unless there is a complication.

There are many of these in the USA and a study was done on them following discussions questioning their safety.

The December 1989, the most prestigious USA journal, the New England Journal of Medicine published a report on the study of 83 free standing birth centres involving 11,000 births. This involved careful scientific analysis and showed there was:-

- very little intervention
- very low infant mortality
- no maternal mortality

Women attending these are as safe and probably safer than being in hospital. The conclusion is that such centres are very safe and a very valid option so we need to be thinking about them. Hospitals are very dangerous places with very dangerous germs, terrible places for the newborn. As only healthy women attend birth centres, these are far safer.

3. Increase Midwife Numbers in the Hospital

Hospitals can be improved by having more midwives there. The improved outcome with midwives as carers is well documented in all settings.

4. Women Support System To Sit With Labouring Women

He suggested starting tomorrow a system of bringing any available women (grandmothers perhaps?) into the labour wards to sit with labouring women. Studies have showed that even when the woman is a stranger, her presence throughout the duration of labour and birth means less obstetric intervention, a shorter labour and a better outcome. It is important to provide this support to women for this purpose. It doesn't cost anything to implement either.

A NZ study has been done which shows a significant increase in pain relief following a shift change. This can be avoided by having the support woman there.

5. Put Locks On the Doors of Labour Rooms

The hospital is Drs space, but a lock on the inside of the door of the labour room offers the woman some control, and a feeling that this is her space, altering the power structure. Everyone then has to knock on the door and explain why they want to come in.

6. Make Home Birth A real Choice For All Women

The health system must honour this choice and make efforts to ensure it is readily available to women so they don't have to fight for it.

In most European countries, the right to choose is law. Everyone understands the right of the family to determine their destiny and make their own decisions. This needs to be restated in NZ.

There are clear attitudinal differences between women choosing home birth and hospital birth. Those who choose birth centres have attitudes that are closer to those choosing hospital birth so birth centres will never be a replacement for home birth. Some women feel more comfortable in an institutional situation.

Attending home births rate as one of the most profound experiences he's ever had. Women go into pain, go through the pain and come out the other side. By allowing the normal physiological process to happen, endorphines (endogenous morphine) are produced which provides pain relief. The denial of pain in western culture has a generation of women believing pain is evil rather than positive.

7. Informed Choice

Birthing women need all the information. This will help to correct the myths about epidural and babies not dying. Although the USA has what he considers to be the world's worst maternity service, the states of Massachuscetts and New York have made it a legal requirement for hospitals to present their statistics upon demand. Birthing details are no longer a secret.

The global trend for access to individual medical records is now extending to service information and statistics. This is no longer just the domain of Drs and it is the consumer's right to know.

Informed Choice is not consent which actually means to obey. This can be observed in hospitals where Drs permit women to walk around and have their husbands present etc...but they can't do.....

Women have to have true choice & this issue was dealt with in a book published by WHO on " Having A Baby In Europe " which he feels applies to all industrialised countries. It describes how essential it is for a woman to feel in control so she is able to open herself confidently to give birth.

Being in control is more important than what is chosen

NZ needs to turn things around to make women feel they can give birth. The community of women have to get organised. NZ is very badly in need of better perinatal information. We should be demanding this and using the media to educate women about birth and death, and about midwifery. Midwives and women must work together and collaborate together.

PROMOTING WELLNESS

The New Zealand Health Charter

THE NEW ZEALAND HEALTH GOALS

- To reduce the onset of smoking in non-smokers, especially adolescents, and to reduce the number of smokers and the consumption of tobacco.
- To reduce the incidence of dietary related health disorders by improving nutrition.
- To reduce alcohol-related health problems by reducing alcohol consumption.
- To reduce the prevalence of high blood pressure.
- To reduce preventable death and disability from motor vehicle crashes.
- To reduce hearing loss in children in the under five year age group.
- To reduce disability and death from asthma.
- To reduce avoidable illness and death from coronary heart disease and stroke.
- To reduce the incidence of invasive cervical cancer and the cervical cancer death rate.
- To reduce skin cancer (melanoma) incidence and death rates.

Each of these are broad goals which will have defined targets and strategies set within them.

According to the Minister goals were chosen on the grounds that:

"their achievement will significantly improve the overall status of the public of New Zealand. Health status will be deemed to have improved if life expectancy is increased or avoidable mortality or morbidity is reduced, and the average number of years that people live free from major diseases or disability is increased."

Area health boards are responsible for incorporating the above goals into their strategic plan. A performance orientated accountability agreement between each board and the Minister will be the basis of contracts to be drawn up under the new charter. The annual negotiations of the contract will involve a review of the board's performance during the previous year, and ways of improving the use of public health funds.

The health care principles outlined in the charter provide the basis for identifying criteria for the selection of goals and targets. The six criteria for selection were:

1. The health problem is an important cause of death, disease or chronic disability.
2. Achievement of goals and targets should reduce social and ethnic inequalities in health status.
3. The health problem must be amenable to measurable change, either through primary or secondary prevention or through more effective medical management.
4. The targets must be feasible and involve improvement in health outcomes compared with present trends.
5. The targets should be resource realistic and their achievement should not be at the expense of other important health outcomes at either the national or regional level.
6. The goals and targets should incorporate an appropriate balance between treatment services and disease prevention and health promotion.

The philosophical thrust of the health goals is to promote wellness. The reorganisation of the health system places responsibility for attainment of the health goals and targets by the year 2000 with the fourteen area health boards. The role of the Health Department has changed so that it no longer has an operational involvement at the local level. This role has changed to one of health policy development and monitoring. The Minister of Health summarises this change in the following statement

> *"While it will be the individual area health board's responsibility to manage and plan within its region, there must be both leadership and co-ordination within the system to ensure that we are all heading in the same direction if the New Zealand health service is to achieve national goals and targets. There needs to be more national leadership on what we are trying to achieve and local responsibility for determining how we should achieve this."*

Thus, while the Health Department will monitor and evaluate the effectiveness of each area health board in meeting these objectives, the boards in turn, will monitor the Health Department with regard to its ability to provide policy direction, co-ordination and leadership. The consumer will need to monitor both to ensure that the end product is improved health for all.

Patient Complaints System for Health Services

The Minister of Health, Helen Clark, has announced the introduction of legislation to Parliament, later this year, to establish the Office of the Health Commissioner, and a nationwide patient advocacy system. Together these will provide customers with access to an independent patient rights and health complaints system.

In a *media* statement, Helen Clark said, "For too long, accountability to the client has been seen in terms of getting the diagnosis right, rather than in terms of patient rights, or providing information to clients about their health care."

She continued, "The Health Commissioner legislation will fill an important gap in our health service by providing consumers with a complaints system which is accessible, user friendly and inspires confidence."

The proposed legislation is another of the Government's steps to fulfil the recommendations of the Cartwright Report, in this case, that

- a Health Commissioner be appointed;
- a statement of patient rights be provided; and
- a patient advocate system be developed to cover all New Zealand hospitals.

The Health Commissioner

A wide range of possible functions for a Health Commissioner have been discussed. These functions are based on those outlined by Judge Cartwright which were –

- involvement in the mediation and investigation of complaints
- education for health professionals in the area of patient rights
- the ability to apply for sanctions and remedies in case of the breach of patient rights.

Patient rights

The rights of patients should include –

- the right to give informed voluntary consent to patient care services
- rights to privacy and confidentiality
- rights in relation to participation in teaching and research
- rights in relation to information collected for management and epidemiological purposes
- rights of access to complaints procedures
- rights in relation to appropriate standards of care regardless of a person's ethnicity or gender.

Patient advocates

The role of patient advocates may include –

- being available to hospital patients and users of the health services who have queries and complaints
- working alongside hospital staff and health care providers to deal with complaints and provide information
- mediating when there are differences between staff and patients
- referring complaints to the Health Commissioner when they cannot be resolved.

Complaints will initially be mediated at the 'lowest' level by the advocates and the Area Health Board or hospital concerned. Those not able to be resolved at this level may then be taken up by the Health Commissioner and if necessary put to a body such as the Equal Opportunities Tribunal.

Independence important

It is crucial that both the Health Commissioner and patient advocates are seen to be independent from health providers. For this reason, the Health Commissioner will be appointed by the Governor-General and will be accountable directly to the Minister of Health.

Similarly, the patient advocates will be appointed by, and be responsible to, the Health Commissioner, rather than to individual Area Health Boards.

Women use the health services more than men do. This is because women bear children, raise children and care for the elderly. Also women live longer than men and are therefore more likely to become dependent on the health system as they grow older.

The findings of the Cartwright Inquiry have undermined women's confidence in health service provision, and have demonstrated that there is currently little accountability to women patients in the health system. It may therefore be appropriate for the Health Commissioner to be a woman.

The skills of the Health Commissioner and patient advocates will need to include familiarity with the health service, knowledge of the community, a good awareness of tikanga Maori, knowledge of the needs of migrant and other minority groups, legal, mediating and negotiating skills, and being a good listener with good judgement.

Health Commissioner Bill

This Bill was introduced in Parliament on 5 September. The Bill proposes the appointment of a health commissioner to serve as an ombudsman for the health services. The commissioner would investigate complaints against health care providers and prepare a code of consumers' rights. In addition, it would allow the setting up of a health consumer advocacy service, with the appointment of a series of advocates who would take up public complaints close to the source and work to resolve them.

The Bill has been referred to the Social Services Select Committeee. The closing date for submissions is not yet available. All people interested in health care or consumer issues would be advised to ensure that they make representation.

The Bill of Rights Now Law

The Bill of Rights received its third reading and passed 36 votes to 28 on 24 August. The final bill was a watered down version of the original in which Mr Palmer had wanted the Bill of Rights to be New Zealand's supreme law with the courts able to use it to over-rule other legislation passed by the Parliament if the freedoms guaranteed by the Bill of Rights were being damaged. However, an additional clause to the bill makes it clear that Courts cannot use the Bill to over-ride other legislation.

The catalogue of rights in the bill covers many basic civil liberties and includes:

- the right not to be deprived of life, not to be subjected to torture, cruel treatment or medical experiments and to refuse to undergo medical treatment.
- the right to vote for New Zealand citizens 18 years and over.
- freedom of thought, conscience, religion and expression, and to worship.
- freedom of peaceful assembly, association and movement including the right to leave New Zealand.
- freedom from discrimination on the grounds of colour, race, ethnic or national origin, sex, marital status, religious or ethical belief and a guarantee of the rights of ethnic, religious or linguistic minorities.

The Bill also clearly sets out the rights of those arrested, searched or detained.

The Aids Foundation and the National Union of People Living With AIDS were quick to criticise the Act for the Government's failure to include "sexual orientation" and "disability" in the anti-discrimination clause. These groups strongly argued that this failure indicated that the Government was not prepared to match their own verbal submissions with action.

New Zealand had co-sponsored resolution 41.24 of the World Health Assembly which urged member states to protect the human rights and dignity of people affected by HIV/AIDS and to protect them from discrimination and stigmatisation in the provision of services, employment and travel.

Contraception, Sterilization and Abortion Amendment Bill

Following the third reading of this Bill, it will now be legal to provide contraceptive advice to people under the age of 16 years. It was strongly supported by the Minister of Health Helen Clark, who was concerned that people under 16 should have the information they required to make sensible decisions about their sexuality.

Employment Equity

In June the Employment Equity Bill was reported back to the House by the select committee who had considered more than 300 submissions from individuals and groups.

The Bill remains substantially unchanged from the first reading.

The general objectives of the proposed legislation remain as follows:

- To promote equal employment opportunities and eliminate discrimination from all forms of public and private sector paid employment.
- To identify those areas of paid employment in which discrimination exists.
- To address the impact on women of any current or historical discrimination in their paid employment.

Two changes are that employment opportunity targets must now be met with merit as the primary criterion and a pay equity assessment is now defined as a gender neutral assessment.

When the Bill was returned to Parliament for the second reading, Minister of Labour Helen Clark, said, "The employment equity legislation will ensure that, once in the workforce, women have an equal chance of succeeding and getting paid fairly for the work they do."

The Minister of Women's Affairs Margaret Shields, said, "The Bill marks the coming of age of the Ministry of Women's Affairs. The Ministry has facilitated women's access to the decision-making process so their needs can be met by legislation."

The Domino Option

NORTHLAND AREA HEALTH BOARD

AUGUST 1989 - JULY 1990

The Domino option is a new service that believes that women who get to know their Midwife before they go into labour will need less ante natal admissions, feel more in control of the labouring experience, need less narcotic analgesia, and less medical intervention in the labour and birthing experience. The continuity of the midwifery support into the post natal period, decreases the multiplicity of advice and increases successful breastfeeding patterns. The National Home Birth Statistics of New Zealand reflect the benefits of continuity of care, commitment to support of natural childbirth, where appropriate, and education to increase healthy living styles, and the rejection of unnecessary intervention. The challenge for the Domino Option is to try and reflect some of those statistics. The Domino Option also acknowledges that the majority of New Zealand women have been socialized to view hospital birthing as a safer option than home birth. The Domino Option is committed to ensuring that women return to their own home environment as soon as it is practical after the birth. We believe that a women's own home is a more appropriate place to develop parenting skills and problem solving, for low risk women, and that the hospital setting is only appropriate for women needing high risk post natal support.

The following statistics represent the first 70 Domino Births

Normal deliveries - 65

Ventouse assisted - 3

Caesarian Sections - 2

- 1 - failure to progress, meconium liquor, feotal distress
- 1 - premature twins

Primipara - 20 = 29%
Multipara - 50 = 71% similar to the balance of primigravida in usual system

Positions for giving birth in order of most common use:

- kneeling
- birthing stool
- sitting
- hands and knees
- squatting
- standing
- dorsal, lithotomy, lateral

Pain relief - sublimaze 7
pethidine 5
epidurals 2

total narcotic combined = 17%

Intervention - Prostin inductions 4 = 6%
- 3 for post dates more than 42 weeks gestation
- 1 for increasing antibody litres

Augmentation of labour with syntocinon - 2

Perineal repair Episiotomy - 2
Sutured lacerations 30%

Complications pph 5
Neonatal death 1 complications of a breech birth

Numbers not able to go home within the prescribed time

Complications with the baby - 4
- 1 early onset jaundice
- 1 prem
- 1 jaundice from antibodies
- 1 birth asphixia

Reason to do with the mother - 9
- 4 pph
- 2 C/S
- 3 Social pressure

Breastfeeding - 2 decided to artificially feed
- 68 fully breast feeing by the end of 2 weeks
Of those, - 4 gave a single milk comp
- 3 gave small amounts of boiled water of a teaspoon

COST JUSTIFICATION

The Domino Midwife has a contract with the Minister of Health which pays for all services occuring in a women's home . i.e. ante natal care, home birth and Post Natal care.

For women electing to give birth in Hospital under the Domino Option the Northland Area Health Board pays the Domino Midwife the equivalent rate due to a Domiciliary Midwife for the labour and birthing care, even if the early part of the labour is supported at home.

At the moment the Domino Midwives (2), are paid as well as Delivery Suite maintaining the same midwife cover. As more midwives work on the Domino scheme and as the demand increases, it will be possible to decrease the rostered cover for delivery suite and have a greater pool of Domino midwives and 'On Call' staff to provide the same cover for no extra cost.

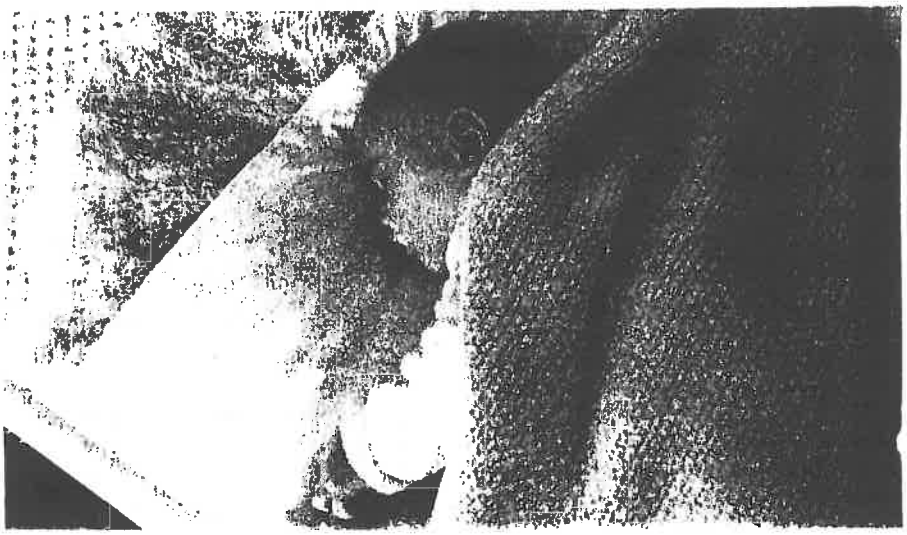
Cost savings are made from the non use of Post natal services at a cost saving at $200.00 per day.

Lynley McFarland

Domino Midwife

Domino scheme for South Wellington

Thea Roorda



Pregnant women in the South Wellington area now have access to their own DOMINO midwifery service.

The DOMINO service (meaning domiciliary midwife in and out of hospital) means women can have the same midwife throughout their pregnancy, delivery and postnatally. The scheme provides three antenatal visits to the woman's home which gives the woman an opportunity to get to know her midwife. When the woman goes into labour the midwife comes to her home or meets her at the hospital and stays for the entire labour and birth. Two to six hours afterwards the woman returns home with her baby and the same midwife continues her care with up to 12 postnatal visits.

The Wellington service has been set up as a one-year pilot scheme by two midwives who have contracts with the Wellington Area Health Board (which covers the birth) and with the Department of Health (for ante and postnatal visits). The service is free.

One of the midwives, Carey Virtue, says they had found as shift workers in maternity hospitals they were having to pick up or leave women at crucial times in their labours. "Women were saying clearly to us that they would like to know their midwife in advance and that they would like to have continuity of care."

Interest in the service has been so great that the midwives have had to restrict the service to women in the south Wellington area. They are keen that the service be made available and accessible to women of all cultural backgrounds. The main aim is to provide women with a choice about how they want to give birth. Carey Virtue said that knowing the midwife can reduce the fear many women have in coming into a strange building, and give them more confidence to cope in labour.

This view is shared by Newtown (Wellington) general practitioner Dr Julia Carr who says that many women were shocked to find that the midwife who took their antenatal notes was not the same as the midwife who looked after them during delivery. "After sharing a lot of information about herself she may never see the midwife again."

Dr Carr believes the problem is not individual midwives, who put a lot of time and energy into their work, but the way hospitals are structured so midwives do not always get time to develop a rapport with women in labour. "The midwife may be caring for two or three women at the same time and women can be left feeling they are not getting the support they need.

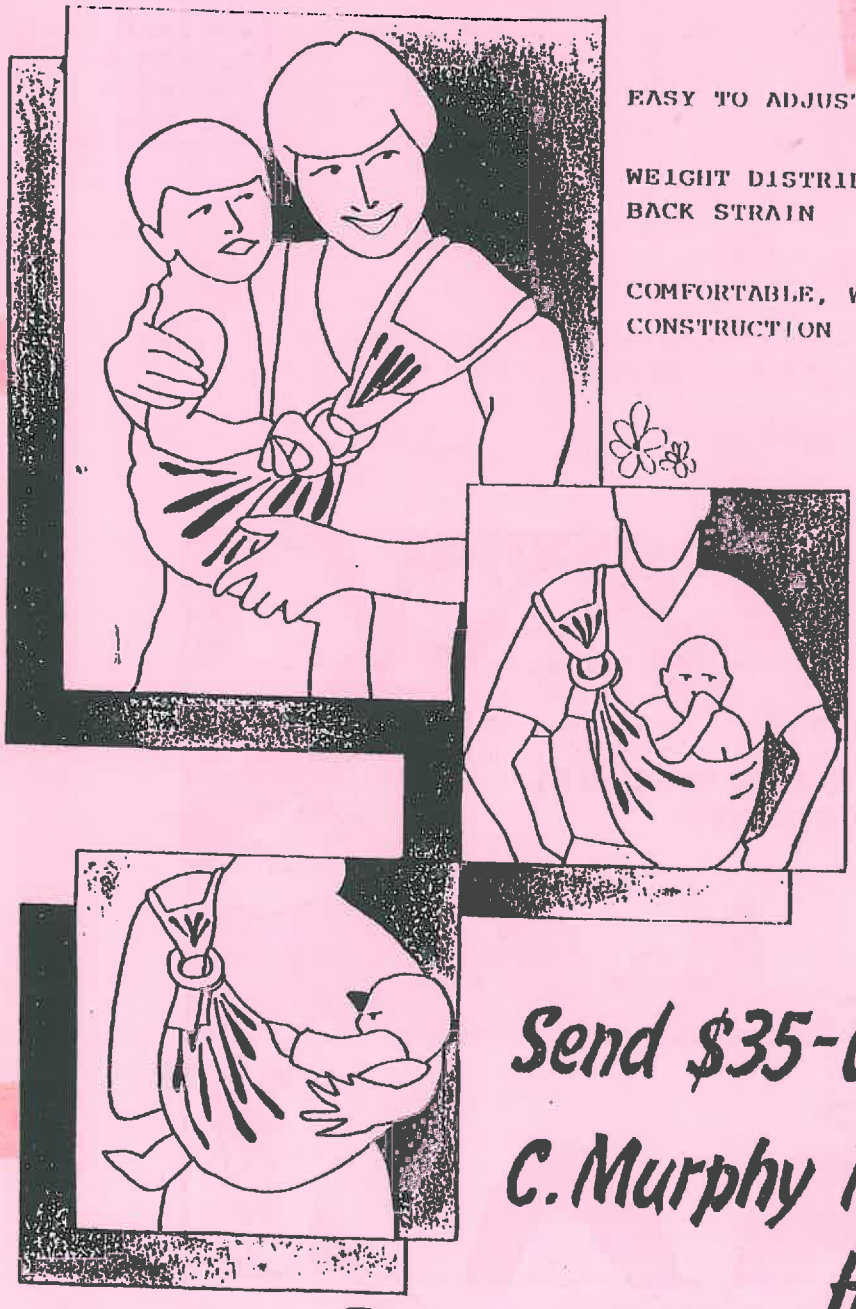
"Women often ask for pain relief after a change in shifts, indicating the stress involved in getting used to another midwife."

Dr Carr also says that the service will benefit women for whom English is a second language. Dealing with just one midwife means a woman is more likely to be understood and less likely to be confused by conflicting professional advice. She said other general practitioners in the area had expressed support for the service, as had other midwives working at Wellington Women's Hospital.

BabySling

NEW ! IMPROVED VERSION!

Accommodates babies from birth to 3years



EASY TO ADJUST AND FITS ANY SIZE ADULT-BABY PAIR

WEIGHT DISTRIBUTED OVER SHOULDER AND HIP TO AVOID BACK STRAIN

COMFORTABLE, WELL PADDED, DURABLE 100% COTTON CONSTRUCTION

POSITIONS:

- CRADLE HOLD FOR DISCREET BREASTFEEDING
- FORWARD FACING
- TUMMY TO TUMMY
- HIP STRADDLE

Send $35-00 (includes p+p) to

C. Murphy R.D.2 Kaihinu

HOKITIKA

Colours : Pink or Blue

SAVE THE MIDWIVES ASSOCIATION INC. - Subscription Form
Please post to Brenda Hinton, 2 Sherwood Ave, Grey Lynn, Auckland

NAME:

ADDRESS:

PHONE:

MIDWIFE?____ MOTHER?____ OTHER?____ NEW?____ RENEW?____

ANNUAL SUB. (Your choice) $20____ $10____ $5____
INTERNATIONAL SUB - $NZ25____ **AUSTRALIA** - $NZ20____

ENCLOSED DONATION -
Send self addressed envelope for receipt if required

SENDER:
16 McEntee Rd.,
Waitakere,
WestAuckland.

MIDWIVES
DELIVER
BETTER
BIRTHS

Liz Jull
Te Tauwa
Waitohu Valley Road
OTAKI