

## Response Two: From the Midwife

Karen Guilliland

Director, New Zealand College of Midwives

The National Health Committee (NHC) report was disappointing and unsatisfactory on a number of levels.<sup>1</sup>

When this review was announced by the government, the New Zealand College of Midwives (NZCOM) expressed concerns about the validity and therefore the usefulness of consumer survey as a methodology on which to base policy and funding decisions. There have been numerous surveys of this type over the last few years and it was the College's view that the NHC's methodology would be unlikely to present providers with additional insights or reliable evidence-based information.

The gaps in services around information about maternity options, audit, rural and Maori women's access and postnatal care have been consistently identified by all health professionals and maternity groups for a number of years. Not surprisingly, the NHC review findings confirm these issues.

Given that the NHC chose to base its review on consumer satisfaction, it is reasonable to expect the review's recommendations would be based on the survey findings. These findings confirm the women-centred model as appropriate, and what women want. It identifies: maternity facilities as under-resourced, dirty and with inadequate staffing; poor performance management by the HFA; stressed rural services that are inconsistently funded; and a public poorly informed of the maternity services available. These are largely systemic problems that are the result of government or health agency policy and decision making. The NHC, however, has concluded that the relationship between doctors and midwives is the causative factor and many of its recommendations are influenced by this conclusion. It appears they have also been unduly influenced by their concomitant project in relation to primary care organisations (PCOs). The basis of PCOs, according to the NHC, relies on the general practitioner as the pivotal base for all medical and health care. This ignores New Zealand history which has relied predominantly on Plunket nurses, Family Planning clinics, sexual health services, men-

tal health nurses, public health nurses and occupational nurses to provide health services. These health providers will of course refer to general practitioners and the primary medical system as required, but it is the health provider who has been the pivotal contact. The maternity services, since the early 1990s and the advent of independent midwife practitioners, have added another dimension to the primary health team. Recent contracting by the HFA has undermined this national primary health system in favour of numerous direct contracts with IPAs, and the NHC recommendations further develop the primary medical care pathways with their approach. The recommendations therefore are based on this ideology and apparently have not considered the achievements of the current system.

In relation to the current midwifery services, for example, the report found that women with a midwife Lead Maternity Carer:

- Were most likely to agree they were given enough information to choose an LMC. Least likely was if their information came from another doctor (not their family general practitioner) or multidisciplinary hospital team.
- Were more likely to feel confident (93 per cent) that they would be referred as necessary than if their LMC had been a general practitioner (87 per cent). They were least confident if their LMC was the multidisciplinary hospital team (84 per cent).
- Were consistently more satisfied with pregnancy care. Multi-disciplinary teams provided the least satisfaction in two surveys.
- Were more likely to be happy with their hospital care than other women.
- Were more likely to express high levels of satisfaction than with other LMCs. Apart from postnatal care LMC obstetricians also received high satisfaction levels.
- Were more likely to be satisfied with their care during labour and birth. General practitioner and multi-disciplinary hospital teams and shared care (in that order) were least satisfactory in the NHC surveys.
- Were more likely to be satisfied with their care after the baby was born.

Obstetricians, shared care and general practitioners were the least satisfactory (in that order).

- Were more likely to receive five home visits postnatally than other LMCs.
- In all surveys showed considerable consistency in expressing the highest satisfaction and lowest level of dissatisfaction.

These findings indicate that the independent midwifery option needs to be supported and developed. However, despite their own evidence of the midwife LMC as a consistently high performer, the NHC went on to recommend a structure which essentially undermines the midwife LMC in favour of strengthening the role of general practitioners without maternity qualifications to become more involved in pregnancy and maternity care. There are also no suggestions for supporting the GPO. The fees for non-qualified general practitioner visits are to be higher than GPOs and midwife LMCs. They promote multidisciplinary 'teams' and doctor-led primary care organisations, despite their own findings from women that these models were the least satisfactory.

The report recommends or encourages:

- Allowing second and third pregnancy trimester consultations with a general practitioner. The fee is to be higher than that received by maternity providers. There are no requirements for the general practitioner to be qualified in obstetrics or to inform or consult with the LMC over these visits. This fractures continuity of maternity care and deprives the LMC of essential information.
- Fee for service for non-LMCs during four weeks postpartum. This fee is to be at a higher rate than that for maternity providers.
- Relinking mother and baby with the primary health provider via a six-week postnatal check. This is assumed to be the general practitioner as they are identified as the pivotal 'continuum of care'. This ignores the fact that Plunket is the predominant well child provider. It also ignores the fact that the six-week immunisation is the most successful immunisation contact under the existing

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## News from the Independent Biotechnology Advisory Council

Professor Donald Evans continues his work as a member of the Council. Notable progress has already been made with respect to each of the roles of the Council.

Its first responsibility is to inform the New Zealand public about developments in Biotechnology and to identify the public's concerns. To this end a wide selection of stakeholders have been interviewed by the Council including representatives of: political parties; the biotechnology industry; agriculture and horticulture; food manufacturers and purveyors; the Ministries of Trade, Environment, Health, Research, Science and Technology; and the Environmental Risk Management Authority.

In addition 20,000 copies of the booklet published by the Council entitled *The Biotechnology Question* have been distributed across the country. It is also available on the internet on the website [www.ibac.org.nz](http://www.ibac.org.nz). This booklet explains what biotechnology is about in a readily accessible form. It sets out the possible benefits of these technologies and canvasses the major ethical problems presented by them. The booklet contains a questionnaire which members of the public are encouraged to complete and return to indicate to the Council which problems they would like to be examined.

Focus group meetings have also been convened all around New Zealand made up to ascertain the views of the youth, the aged population, rural communities, inner city dwellers, and so on. The closing date for returns of the questionnaire is 1 November. Thereafter the Council will tackle the large task

of collating and analyzing the data collected.

The second responsibility of the Council is to advise the Minister of Research, Science and Technology on specific matters from time to time. The first piece of advice has already been delivered and actioned by the various ministries responsible for the control of genetically modified crops in New Zealand. The Council has advised that a moratorium on the processing of applications for field release of genetically modified crops be imposed until the Council has had time to review the various issues surrounding such a release. At the moment New Zealand is entirely free of such crops, except for those grown in confined research projects. It might turn out that the Council, after reviewing the issues, will be convinced that the field release of such crops is not in the interests of New Zealand and the New Zealand population. If field release has already occurred by then the Council's advice will be offered too late for it to be of much use, as the horse will have bolted already from the stable.

It has become clear from the exploratory work which the Council has completed that it has a much larger task to perform than was apparent at its inauguration. The Council is concerned to demonstrate its independence from political and other vested interests in the Biotechnology debate. This is a difficult task given the ideological character of much of the public debate on these issues.

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LMC system. The problem areas are twelve and eighteen months and well outside maternity.

- Promoting the role of the general practitioner in 'higher risk women', despite identifying adequacy issues around general practitioner education.
- Ensuring one person is accountable for co-ordination of maternity care but removing financial accountability. In other words deconstruct the LMC model which produced the 'excellent women-centred service' reported.
- That financial accountability be held by an 'entity' other than an individual LMC. This is particularly incongruent with the findings of the review which clearly indicated LMC midwives as the most satisfactory service.
- That professionals work in 'teams'. Again incongruent with the report's findings that multidisciplinary teams provide women with the least satisfactory services. The nature of team work is also problematical in a health service where maternity units have closed, there are no general practitioners in some areas, most general practitioners do not hold a diploma in obstetrics, and most of those who do are unwilling to provide maternity services. Furthermore, there is a significant number of women who do not have a regular general practitioner.

Altogether an extraordinary report, flawed, non-factual in parts and opinion based, clearly written to meet another political agenda.

### Note

<sup>1</sup> NHC Review.