Article

Private Or Public: Is There Really a Difference?

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The past eight years have seen significant changes to the way maternity care in New Zealand is delivered: the basics of obstetrics and midwifery have not altered significantly but the politics have.

There is no mistake in suggesting that funding has been a significant force in shaping maternity care; changes to Section 51 both past and pending have brought more to focus the similarities and differences in public and private maternity care. Which direction should New Zealand take?

It would be unrealistic to tackle this subject without a brief historical perspective. Prior to the 1960s there existed not only base hospitals for provision of secondary and primary maternity care but also private maternity homes that were run by midwives, doctors or organisations. Gradually these private facilities closed with the promise that all maternity care would be funded by the government and that practitioners would have equal access to the facilities. Specialist obstetricians retained the right to charge a fee to the patient while GPs and midwives could not. GPs retained access to public maternity units and midwives by and large were employed by the hospitals. There were always exceptions in certain locales but this was essentially the scenario. There were midwives who worked outside of hospitals providing homebirth options but, as I understand it, they were not able to access significant public funding.

The situation changed in 1990 with the Nurses Amendment Act which allowed midwives to practise in their own right and claim on Section 51.

Further changes to Section 51 saw primary maternity funding as a source of conflict between providers of maternity care. There were also several conflicts over philosophy of care.

The definition of public and private took on a new slant. There was 'private' care provided by:

1. Specialist Obstetricians charging a fee in addition to the public funding for both private and secondary obstetrics.
2. General Practitioners in private practice receiving public funding for primary obstetrics.
3. Midwives and private practice receiving public funds for primary obstetrics.

Public funding was provided by:

1. Hospital-based specialists in public hospital employ providing secondary care.
2. Midwives in hospital employ providing primary and secondary care.

As times change we see change in delivery and maternity care. Private birthing facilities are making a comeback. Provider groups are competing with established hospitals for funding. Practitioners who are fed up with the current situation are choosing to leave maternity practice. Those who remain are quickly classified as private or public and with this comes the different perspective of what sort of care is given or received.

The terms themselves engender certain feelings in us all. There is competition between codes. There is a perspective that only the rich access private care. Public practitioners are righteous and private practitioners are greedy. (Interestingly enough, to try and distance themselves from the monetary issue, those who are in private enterprise but fully funded from the public purse have referred to themselves as 'Independent'.) There are those who feel that private care is better than public and vice versa. There are many more differences and comparisons that could be highlighted. The simple truth, however, is that none are true all the time and that all are true some of the time. What really is the important consideration of private *vs* public care is in fact the *care*.

The motivation of the caregiver is the factor in the quality of maternity care. There are well motivated and poorly motivated people on both sides of the fence. Some private/independent practitioners are 'in it for the money', no question. However, is that any different from the public employee who gives bad service while still receiving a salary? Continuity of care has often been a reason for people 'going private'. Women want to know their caregiver rather than take potluck with who's on call. All motivated caregivers, both midwife and doctor, would like to give perfect continuity of care. The experienced practitioners know there is an unrealistic expectation, even in private practice. None of us have been able to sustain twenty-four hours a day seven days a week, 365 days a year on call and many of those who have tried have been subject to burnout. However, both public and private can look at organising their delivery systems to do the best they can to deliver a continuity of care within a collaborative practice of doctors and midwives. After all, isn't that what women and their families want? They want our best.

There will always be personality factors. The poor practitioner with charisma will always have a significant following. People will always 'go public' because they feel that it is their right and other people will always 'go private' because of the trappings and the feeling that if you pay for your care you will get better care.

Some of the public/private split has occurred because practitioners have felt that they could not give their best in the public environment and so have created an environment of their own. Some have found it necessary to supplement the public system income. Some public providers have encouraged their practitioners to reduce the hours they work in the public system and work privately so that the public payroll for that institution will be less.

Competence is another issue; for economic reasons, the brain drain exists in any public industry.

A private sector of any public industry will survive only if it is economically viable. Even people who are committed to the delivery of a public maternity service will leave if they feel frustrated in their attempts to provide good quality care.

So where does this leave us with the question of private and public maternity care? My feeling is that there should be no difference in the quality of care given in public *vs* private. This does not mean that services will be the same. This means that the qualities that make us professionals and make us responsible maternity caregivers will not change with regard to who pays the bills. The key is to get good quality people who are sensitive, caring and competent to fill the roles of midwives and doctors.

The people to fill these roles come from a programme of good role model-type teaching. Role model teaching has to be as much a part of our health care delivery as does the delivery of the life-saving procedures that we are trained for. There is no reason that this role model-type teaching can't occur in both the private and public sector.

On a personal note, I have worked on both sides of the fence. I have trained in a private teaching hospital and have worked in the public sector, then become a fulltime private practitioner and am now back into public sector practice. My motivation has been and still is to equip myself with the knowledge and skills to be competent, and to use those skills in a caring and sensitive way to effect a high standard of maternity care.

We must remember that no matter how noble we wish to appear, we still earn a living through our profession. If the patient pays directly we call it private, if the patient pays indirectly through taxation we call it public.

At the Centre

Bioethics Summer Seminar

Planning is well underway for the Bioethics Summer Seminar scheduled for 4–6 February 2000. This conference is put on by the Bioethics Centre with assistance from the Health Research Council. James and Hilde Lindemann Nelson have been confirmed as keynote speakers for the conference. They have particular interests in the family and narrative ethics, and reproductive ethics. John Seymour, Adjunct Professor, Faculty of Law at Australian National University, has also been confirmed as another keynote speaker. Professor Seymour is currently writing a book on reproductive law and ethics. Judge Patrick Mahony, Principal Family Court Judge, Trish Grant, Senior Advocate from the office for the Commissioner for Children, and Dr Tony Ruakere, Chief Advisor Maori Health from the Ministry of Health, have all confirmed their involvement. Some of the themes in the Summer Seminar will include innovative therapies, narrative ethics, reproductive ethics, and alternative and traditional therapies. The Summer Seminar will be held at Dunedin's Salmond Hall, renowned for its excellent catering and picturesque setting near to the Dunedin Botanical Gardens. There have already been a large number of preliminary enquiries and we encourage people to enrol early to secure a place and avoid the late fee.

Anyone interested in attending the Bioethics Summer Seminar should contact Fay McDonald, Conference Organiser, Bioethics Centre, PO Box 913, Dunedin. Or by email: fay.mcdonald@stonebow.otago.ac.nz

Arrivals

Dr Jing-Bao Nie and his family arrived in Dunedin in July and he has taken up his appointment at the Centre. Jing-Bao and his wife Lisa and their two children, Lucy and Luke, have settled quickly into life in Dunedin. The have recently bought a house and Lucy has started at a local school.