Midwifery in New Zealand 1990-2003: the complexities of service provision.

by

Christine Elizabeth O'Rourke Hendry

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that this thesis has not previously been submitted for a degree, nor has it been submitted as part of requirements for a degree except as fully acknowledged within this text.

I also certify that this thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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ABSTRACT

This Professional Doctorate in Midwifery explores the development of maternity services in New Zealand subsequent to legislative changes in 1990 enabling midwives to provide the same services as doctors and access the same funding for the provision of care for childbearing women. The papers in this portfolio describe and analyse challenges faced by New Zealand midwives in achieving their full potential as autonomous health professionals and the strategies they developed to survive within a healthcare environment that despite changes, remained medicalised.

Throughout this portfolio, a theoretical framework based on complexity theory provides a lens for critique of the varying challenges to midwifery development and strategies to progress the profession. The seven papers that make up this portfolio were developed and written over a five-year period from 1999 to 2003. During this time I was involved in various activities supporting midwifery in New Zealand, including the establishment of a postgraduate midwifery programme and participation in the refocusing of both the New Zealand College of Midwives and the Midwifery and Maternity Provider Organisation. These activities took me to various parts of the country, enabling me to maintain contact with midwives from a variety of settings.

The first paper sets the scene for the portfolio by exploring the socio-political context of contemporary midwifery in New Zealand. The second paper tracks the emergence of a theoretical framework out of Complexity theory and presents a set of principles, which guide the critique of midwifery services and professional development, explored in the subsequent papers. Part Three documents the development of a contextual scanning tool, used to analyse the organisation of maternity care by midwives in rural settings. Part Four presents the findings of the scan and strategies for consolidating the role of midwives as key providers of maternity services in rural localities. Part Five documents the development of a programme for optimising midwifery leadership within the health sector, while Part Six explores the risks and opportunities for midwives with the development of clinical governance strategies by District Health Boards. Part seven focuses on strategies to increase the potential for midwives to consolidate, maintain and further develop community-based maternity services throughout the country.

This portfolio provides an organisational analysis of contemporary maternity services in New Zealand and presents a multifaceted approach to securing midwifery as a key

health profession and midwives as the main provider of maternity services to women in this country. The findings of this collection of works, identified midwifery in New Zealand as precariously positioned within a rapidly changing health service environment. While appearing most vulnerable, midwifery within the rural and primary settings appeared to offer the most potential for innovative development in order to secure the place of midwives as the prime providers of health care for women in childbirth.

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ACKNOWLEDGEMENTS

This doctoral journey has culminated in a number of significant changes in my life. If it were not for the support and perseverance of colleagues taking the journey alongside me, I would have given up the struggle long ago. The struggle to maintain full-time work, family commitments, life changes, research endeavours, maintain friendships and most of all have a life, was almost too much at times. Karen Guilliland and Sally Pairman, my Kiwi colleagues on the programme, always guaranteed stimulating discussion during our visits to Australia for seminars. They continued to keep my interest in writing and research going when the pressures of work seemed to overwhelm me. Nicky Leap and Pat Brodie, my Australian colleagues' interest in my research really kept me focused. Sally Tracey, the 'New strailianer' (never sure which side of the fence she was on), whose infectious interest in New Zealand midwifery and her fascination in the perceived ease with which, she believed, we Kiwi midwives seemed to 'manage' the health system in our country, really kept me going in the very dark times. Professor Lesley Barclay, my supervisor, deserves my greatest thanks. She seemed to know how to make me 'produce' work for her to review. Her inspiration over the years and in the end her patience as she read and reread this portfolio actually enabled me to finish. To all the midwives and support staff at the UTS Centre for Family Health and Midwifery in Sydney, thanks for all the good times and Thai takeaways we shared while continuing to talk midwifery. This place became a home away from home for me over the years. A special thanks to my family who lived through the professional doctorate journey with me, always waiting with great excitement at the airport for my return, no matter how late at night. These journeys from Australia became a ritual, as I would be loaded down with duty free goodies and exciting gifts from 'Paddy's Market' down the road from the Centre, always my last stop before the airport! To my husband Peter, daughters Anna and Sarah, and my granddaughter Emily, thanks for your support and patience.

Finally I would like to thank the midwives throughout New Zealand who, one way or another, contributed to this doctorate. In respect for the courageous way in which they translated the vision of the profession in 1990 into reality, I would like to dedicate this thesis to you. I never ceased to be amazed at how so many gentle, ordinary women, with the burden of family and community life, embraced the profession of midwifery in this country and took it to a place we never dreamed of 12 years ago.

GLOSSARY AND ABREVIATIONS

This set of definitions and abbreviations below were developed to inform and clarify terminology that is in common usage in the New Zealand health service environment.

Access Agreement: an agreement outlining terms by which a self-employed maternity practitioner may access a maternity facility for the purposes of providing in-patient care to their clients[1].

Birthing facilities: these institutions (mainly hospitals) have been approved to offer a venue for birthing women. In New Zealand the facilities have been defined within four categories[2].

Birthing Unit: These facilities provide inpatient services during labour and birth, but no postnatal stay.

Primary maternity facility: These provide inpatient services for labour, birth and the immediate postnatal period until discharge home. They are also referred to as:

- Level 0 or Level 1 maternity units
- Cottage hospitals
- Rural maternity units
- General practitioner units
- Community maternity hospitals.

Secondary maternity facility: These hospitals provide additional care during antenatal, labour, birth and postnatal periods for mothers and babies who experience complications and have a clinical need to have care overseen by an obstetrician. They are also referred to as Level two facilities or provincial maternity hospitals/services. They have access to obstetricians, epidurals and caesarean sections.

Tertiary maternity facility: These hospitals provide a regional maternity service for woman and their babies who have high and complex needs requiring access to a multidisciplinary team. These are also referred to as Level three maternity facilities or high-level obstetric units.

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[1] Ministry of Health (2002) Notice issued pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 concerning the provision of Maternity Services.

2 Health Funding Authority (2000) Maternity Services: a reference document.

Continuity of care: This is synonymous with the Lead Maternity Carer concept (defined below). This means provision of maternity care to a woman for the duration of her childbearing experience given principally by the same provider.

Core midwife: A registered midwife who is employed to provide midwifery services within a maternity facility. This role was developed to work in conjunction with the role of the Lead Maternity Carer (doctor or midwife) as outlined in Section 51/88 (MOH, 1996/98) and does not include the provision of continuity of care. These midwives form part of the service outlined in the maternity facility service specifications and are paid by the facility out of the facility fee, not Section 51/88.

Crown Health Enterprise (CHE): The name given to hospital and health services following the market modelled health reforms introduced by the Health and Disability Services Act (1993).

District Health Board (DHB): A representative health organisation, which, following legislation in 2000 was charged by the Ministry of Health to plan, fund, co-ordinate and provide health services for the population in their district. In 2002 there were 21 DHBs in New Zealand.

Independent midwife: This generally refers to a self-employed midwife.

Lead Maternity Carer (LMC): The General Practitioner, Midwife or Obstetric Specialist who has been selected by the woman to provide her comprehensive maternity care including the management of her labour and birth. The woman signs a 'registration form', which is lodged in the health system, naming the specific provider. This provider is the only one who is entitled to payment for the LMC maternity care. The woman has to sign a change of registration form if she wants to have another provider (MOH, 2002), unless she is referred by the LMC to specialist services.

Maternity Benefit Schedule: The public funding and payment mechanism that remunerated midwives and doctors providing maternity care for women in the community, prior to the advent of Section 51 in 1996.

Maternity facility: A facility, mostly hospitals, that provides both labour and birth services and inpatient postnatal care.

Midwifery and Maternity Provider Organisation (MMPO): An organisation established by the New Zealand College of Midwives in 1997 to manage a national midwifery database, provide business support and budget hold for self-employed midwives.

Midwifery Autonomy: This term is synonymously used to refer to midwives who practice without medical supervision and a midwife who takes on a LMC role. Basically this term was used to describe the impact of the 1990 Nurses Amendment Act which enabled registered midwives in New Zealand to practice without medical supervision and claim the same funding and hospital access privileges as general practitioners who provide maternity services.

Ministry of Health (MOH): The government body which funds, monitors and oversees the provision of health services throughout New Zealand.

New Zealand College of Midwives (NZCOM): The professional body representing midwifery in New Zealand with 85% of all practising New Zealand midwife members (Communication with CEO of NZCOM, 2002).

Regional Health Authority: This organisation emerged out of an amalgamation of the four Health Funding Authorities in 2000 as an attempt to mitigate the impact of the funder:provider split.

Secondary maternity services: Provision of comprehensive specialist obstetric services for women antenatally, in labour and birth and during the postnatal period. This includes specialist referral services including obstetrics, paediatrics and radiology.

Section 51: This was issued firstly in 1996, and modified in 1998, pursuant to Section 51 of the Health and Disability Services Act (1993). It provided a detailed service specification and payment schedule for individual maternity practitioners who were taking on the role of Lead Maternity Carer (LMC). This schedule represented a shift from fee-for-service as in the Maternity Benefit Schedule, to a fee-for-case model.

Section 88: Section 51 transitioned into Section 88 of the New Zealand Public Health and Disability Act (2000) when the Health and Disability Services Act (1993) was superseded by this legislation.

PROLOGUE

My personal and professional midwifery experiences have shaped and influenced my interest in the subject of this doctorate; they also gave me a level of access to midwives and their practices settings that would otherwise have been difficult to achieve. My experience of maternity services as a mother, a midwife, a midwifery lecturer, a maternity manager and later within the Ministry of Health as a contract analyst, gave me a greater understanding of the complexity of health service provision in New Zealand. My recent activities as a midwifery lecturer and involvement in the New Zealand College of Midwives (NZCOM) afforded ongoing contact with a variety of midwives from throughout the country.

The professional doctorate provided me with an opportunity to more fully explore and contextualise my own professional activities as a midwife, through analysing the progress of others, while I continued to balance the work of multiple projects. The doctorate has been with me for the past five years, another project, a potentially boundaryless undertaking, that for the purposes of meeting academic requirements is being brought to a close. It represents the product of a reflective journey as I have moved, often as an active participant, through various phases of midwifery and maternity service development in this country.

I have always felt energised by engaging in multiple roles simultaneously. I compartmentalise activities well when needed, yet see connections between them, when an initial glance may have revealed none. I always have a number of projects on hand at one time. If one becomes a burden, I switch to another, yet in the back of my mind I am cognisant a solution for one project may be found in another. The concept of a professional doctorate fitted well with this philosophy.

MAPPING MY MIDWIFERY JOURNEY

I registered as a nurse in New Zealand in 1972, then four years later registered as a midwife. I 'trained' as a midwife in the old hospital-based system (a 6 month apprenticeship followed by a State examination). Following registration I worked part-time in a variety of positions while childrearing. I gave birth to my daughters in the 'old system' with the 'high and hot enemas', plenty of pethidine and unquestioningly agreed to interventions I now know were unjustified. With loud bullying midwives and the fear of making a noise in case I became the talk of the hospital, I would have to describe my birthing experiences as a misery and something I have rarely shared with others. As a

young mother I listened to other womens' stories, most were as miserable as mine. I was ashamed of being a midwife at the time. Fortunately I worked night duty, so few knew, unless I came across them in the dead of night, scurrying with their baby tucked under my arm to slip it into their bed with them for a cuddle and a feed. I hoped the supervisor would not catch me allowing a mother to spend the night with her baby rather then have me 'top it up' with a bottle to 'give the mother a rest'.

During the same time, I also embarked on a sociology degree, rejecting nursing studies which was the only other graduate health education option open to me at the time. The Women's Studies Department had just been established in the Sociology Department at the university. Attendance at some sessions run by this Department gave me the skills and knowledge to more critically focus on my interest and frustrations with 'systems', particularly the health system in which I was working at the time. I also had an emerging interest in organisational management issues, so boldly completed an additional business studies paper at the university where I was one of a few women among the hundred or so in the class. I was in my final year of study, and shocked at the unquestioning use of behavioural psychology as the disciplinary underpinning for business studies. I had difficulty with this 'scientific' and individualistic view focusing on what I perceived to be the manipulation of individual human responses rather than considering the impact of social interaction when theorising how a person would act in a given situation. Sociology had given me a new way of viewing the world.

I was working at a tertiary maternity hospital as a midwife when I finished my degree in 1987. My home life and studies had been compartmentalised away from work and few knew I had been attending university. In 1989, I was invited to become a lecturer in 'obstetrics' in the nursing programme. The following year I moved on to teach midwifery in the 'Advanced Diploma in Nursing' course, a component of which prepared registered nurses to gain registration as midwives. Becoming a midwifery teacher seemed to be a natural progression in my professional life. I was also very involved at the time in the development and establishment of the New Zealand College of Midwives.

The passing of the 1990 Nurses Amendment Act was a memorable event for me and definitely a turning point in my midwifery life. I was teaching midwifery within a post registration nursing programme at the time. At last I had the leverage to set up a separate Diploma in Midwifery programme for registered nurses. This was achieved the following year. The ultimate goal was to set up a three year direct-entry midwifery

programme. This had been achieved in Auckland and Dunedin by 1992. With resistance by the polytechnic Nursing Department (in which the Diploma in Midwifery programme was located), it seemed to me, at the time, an unlikely prospect that a Degree in Midwifery would be established ahead of a Degree in Nursing. I became very disillusioned and weary from trying to bring about change as the sole midwifery lecturer in such a hostile environment.

In 1994, I left teaching to return to practice with substantial experience and new additional knowledge of management principles and a passion for the development of a truly woman centred model of midwifery care. With a group of 14 midwives, I set about converting an urban maternity ward within a general hospital, into a continuity of midwifery care service for local women. We completely remodelled the service, providing total continuity of care for all women birthing in the 10 bed birthing unit. This unit supported about 500 births a year. We reconfigured the physical layout of the ward, renegotiated the midwives' employment contract, developed the role of the core (facility based midwife), moved all the nursing staff to positions as nurses in other parts of the hospital and developed new staffing (non-nursing) roles to assist in the running of the unit. We computerised management and monitoring systems. The midwives and support staff ceased wearing uniforms and women wore day clothes. We also renegotiated the location of the birthing service within the hospital's organisational structure. As the midwifery practice manager of the service I reported directly to the hospital manager rather than the nursing managers or clinical directors. An 'oversight' in hospital restructuring, six months prior to my arrival, had resulted in the unit having no medical staff responsible for clinical services, a situation I was keen to maintain!

During this time I completed a Masters degree in Public Health in 1996 with a dissertation exploring the development of indicators of quality maternity hospital care[1]. I also became increasingly involved in the management of projects for the hospital as a whole. I managed the establishment of a respiratory rehabilitation service on the same principles as the birthing service, which were patient centred. For 12 months I took on the role as Director of Nursing of a large tertiary hospital, which had recently undergone a very public inquiry into patient safety and improved systems of delivering better quality services.

[1] *A comparison between consumers' and providers' perceptions of quality maternity hospital care.* Unpublished thesis. Otago University (NZ)

In 1998, I decided to return to midwifery education part-time and take up consultancy work in a project management capacity. In the following five years I managed over 40 projects. These were not always restricted to the area of maternity services and included hospital design and staffing reviews, auditing of both services and health education programmes, contract reviews, contract negotiation and management for the Ministry of Health (mainly in maternity, sometimes in disability services), independent service reviews and service evaluations. I also formed part of a multidisciplinary research team investigating clinical leadership and the development of clinical governance structures within health services in New Zealand. I also became a board member of the Clinical Leaders Association of New Zealand (CLANZ), a multidisciplinary organisation with the goals of supporting the development and maintenance of clinical practitioners in leadership and management roles within health services. These activities have all informed and enhanced the professional doctorate journey. The relationships between my academic and professional journey, for the duration of the professional doctorate, will be described at the beginning of each part of this portfolio.