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**Consumer Participation in Maternity Service Development in
New Zealand in the 1990s: An Applied Model for Use in
Health Service Planning and Evaluation.**

A thesis presented in partial fulfilment of the requirements
for the degree of Doctor of Philosophy in Health Management
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Abstract

In New Zealand throughout the 1990s, primary maternity services were the subject of considerable debate. The funders of public health services clearly signaled early in the decade that a reconfiguration of the framework for funding primary maternity services was imminent, and proceeded to involve both health professionals and consumers in discussions about the emerging new framework. The chief feature of the new framework which was implemented in 1996 was the concept of the lead maternity carer – a health professional nominated by each pregnant woman to provide and co-ordinate her care throughout the maternity episode.

The body of research work which is the main focus of this thesis commenced prior to the 1996 implementation of the new framework. It took the form of a sampling frame for consumer perceptions of maternity services, with data collection periods in 1995, 1997, and 1999. Throughout this period, approximately 70 women were interviewed and over 3,000 responded to surveys. The main objectives for this sampling activity were to ascertain whether or not women's satisfaction with maternity services changed following implementation of the new framework, and to identify particular aspects of service delivery where changing levels of satisfaction were evident. In general, the new style of maternity service delivery was evaluated positively by research participants. Satisfaction with most aspects of primary maternity care remained constant and high for each data collection period.

The core objectives evolved as the study progressed to include the proposition of a model for best ensuring consumer participation in health service development during periods of major change. The model consists of prospective and retrospective consultation, consumer representation during the process of detailed and final decision making, and a longitudinal sampling frame for consumer perceptions which includes pre and post implementation phases. The application of this model to the reform of primary maternity services in the 1990s enabled consumers to exert influence over the nature of the changes and to be instrumental in the validation and retention of those changes.

The model proposed here has broader applicability to major reviews of other health services. Decision makers in the health arena will come to rely on mechanisms such as the model outlined in this thesis in order to plan effectively, educate and inform the public, and achieve decision making which is sanctioned by communities, against the backdrop of inevitable fiscal constraint, burgeoning demand and competing priorities for public health funding.

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Glossary and Abbreviations

fono	meeting (Pacific Island)
hui	meeting (Māori)
iwi	tribe
Pākehā	European, not Māori
whānau	Māori customary extended family
kura	short for kura kaupapa – Māori language immersion school
ACC	Accident Compensation Corporation
AHB	Area Health Board
CHE	Crown Health Enterprise
CRHA	Central Regional Health Authority
DHB	District Health Board
DMSRC	Domiciliary Midwives Standards Review Committee
GP	general practitioner
HBA	Home Birth Association
HBL	Health Benefits Ltd
HFA	Health Funding Authority
HHS	Hospital Health Service
KYM	Know Your Midwife scheme
LMC	lead maternity carer
Notice	<i>Notice Issued Pursuant to Section 51 of the Health and Disability Services Act 1993 Concerning the Provision of Maternity Services</i> (1998). Wellington: Health Funding Authority
NZCOM	New Zealand College of Midwives
NZHIS	New Zealand Health Information Service
NZMA	New Zealand Medical Association
RHA	Regional Health Authority

Cited Acts of Parliament

Nurses Act (1971)

Amendment to the Nurses Act (1983)

Amendment to the Nurses Act (1990)

Area Health Boards Act (1983)

Health and Disability Services Act (1993)

New Zealand Public Health and Disability Act (2000)

Social Security Act (1938)

Chapter 1: Introduction

“Every act of creation is first of all an act of destruction.”

Picasso

Change processes are rarely free of casualties, yet change is an inescapable part of the evolution of the health sector, both locally and internationally. Reform efforts in every Western nation are responding by necessity to the influences of ageing populations, rapid advances in medical technology and pharmacology, and vastly expanded public expectations and demands (Blank, 1994). How do planners and funders select the changes that are worth making, and perhaps more crucially, the changes that are worth keeping, in a sector where decision making encompasses life, death, degrees of wellbeing and, in New Zealand’s case, \$NZ 7 billion per annum of taxpayer funds? The Health and Disability Services Act (1993) which provides the legal context for the decisions examined in this thesis set out the following six principles as a basis for decision making: equity, safety, effectiveness, acceptability, efficiency, and risk management. The fourth principle – acceptability – when adequately applied can address the remaining principles with useful results (Nuthall, 1997) and is ultimately pre-eminent given that in the end, our health systems have to serve their users – and fit in with the larger values of New Zealand society (Scott, Fougere and Marwick, 1986). One way of ensuring that health services are acceptable to users is to involve them in decision making when services are being planned or reviewed. The belief that the public has an active part to play in decision making about health services is one that is shared across political party lines in New Zealand. A pluralistic model which defines ‘the public’ as being made up of various more or less specialised ‘attentive publics’ (Blank, 1994) is usefully representative of the situation which exists in New Zealand and many other Western nations. The focus of this thesis is how the principle of acceptability has been applied in recent years to that section of the New Zealand public which is attentive to the way maternity services are delivered.

The model presented here is one way of maximising acceptability from the consumer’s viewpoint when developing and maintaining new ways of delivering services in the health sector. The model evolved as part of the process surrounding the 1996 maternity reforms which substantially changed payment arrangements for primary maternity care in New Zealand. This example required a particularly robust model for facilitating input from attentive publics, as the

decisions taken provoked considerable controversy and came under close scrutiny from both the media and specialised interest groups.

This model was not planned in its entirety before being operationalised, but rather was developed progressively on the basis of recognised need at several junctures. The original objectives for this study pertained only to the sampling of consumer perceptions of maternity services in the Central region of New Zealand. These were to ascertain whether or not women's satisfaction with maternity services changed following implementation of a new framework for providing primary maternity services and to identify particular aspects of service delivery where changing levels of satisfaction were evident. However, the introduction of the new maternity framework met with sustained and wide-ranging opposition from general practitioners and their representative bodies. Given this context, the original objectives were expanded to include an examination of the processes designed to facilitate consumer input into the planning and evaluation of the new framework.

The essential processes which were employed over this period of time collectively form a model which could now be applied as part of a planned approach to other similar service reviews in the health sector. The model has two distinct phases – a planning, and an evaluative phase. The planning phase describes processes which should be undertaken prior to the implementation of a major change to a service framework, while the evaluative phase describes processes which should be undertaken after the changes have been implemented. The planning phase includes prospective consultation, consumer representation in discussions concerning the detail of planned changes, and a baseline collection of data relating to consumer perceptions of services prior to the implementation of proposed changes. The evaluative phase consists of a reflective consultation process, and the comparative and review stages of the longitudinal consumer perceptions sampling study commenced in the planning phase.

I approached this work initially as a recent consumer of maternity services. As the maternity reforms which were introduced in 1996 had been foreshadowed since 1993, I submitted a research proposal to the Central Regional Health Authority in 1994 which sought to lay down a baseline of consumer perceptions of maternity care prior to the implementation of any changes, and to provide comparative data through the sampling of consumer perceptions post implementation. The results discussed in Chapters Six and Seven of this thesis pertain to the work undertaken within the geographical boundaries of the then Central Regional Health Authority (Nelson, Marlborough, Wellington, Hutt Valley, Masterton, Hawkes Bay, Wairoa, Manawatu and Wanganui) in fulfilment of this research contract. I was later contracted by the Health Funding Authority to undertake a national survey of consumer perceptions of maternity services in 1999.

The results discussed in Chapter Eight of this thesis concern the work undertaken in fulfilment of this second research contract.

During the period 1995 - 1997, I played a role in another of the components of the model described in this thesis – that of consumer representation. I was the sole consumer representative for much of the national negotiation about the detailed aspects of the new primary maternity services framework which took place between the Regional Health Authorities (RHAs), the New Zealand College of Midwives (NZCOM) and the New Zealand Medical Association (NZMA). The fact that there was a consumer representative involved in these negotiations at all was due to NZCOM's decision to include a consumer as part of its team. As is discussed in subsequent chapters, this aspect of the model, as presented here in its applied format, would benefit from improved process for future applications of the model. A more formal and comprehensive form of consumer representation for this crucial part of the change process should be instigated and supported by the funding agencies at the outset.

The consultation processes described in Chapters Four and Nine were initiated and/or undertaken respectively by the four Regional Health Authorities (North Health, Midland Regional Health Authority, Central Regional Health Authority, and Southern Regional Health Authority), and the National Health Committee. I was not directly involved in these processes, but have recorded them here as essential components of the model which emerged over this period of time.

Taken together these combined processes form a successful model. The first part of this thesis (Chapters Two and Three) sets the model within the local and international context of consumer participation in health service planning and evaluation, with a particular focus on maternity services. The second part presents the essential elements of the model which were used over a six year period in New Zealand in relation to the reform of primary maternity services. The model is presented as an applied response to the question: "How can planners and funders facilitate the participation of consumers in health service planning and evaluation?" The concluding chapter reflects on the companion question: "To what effect?"

Chapter 2: The Local Context

2.1 Introduction

Maternity services in New Zealand share much of the socio-political history relevant to maternity issues throughout the Western world, but there are some aspects of the local maternity environment, particularly with respect to consumer involvement, which set New Zealand apart from the rest of the world.

The following review traces the context for New Zealand maternity services from the watershed Social Security legislation of 1938 through to the present day, beginning with a general overview of health legislation, followed by a specific focus on the maternity climate in the same period and a comment on consumer engagement with maternity issues in New Zealand.

2.2 A Summary of New Zealand Health Policy and Legislation 1938 - 2000

The first major legislative impact on the New Zealand health sector took the form of the 1938 Social Security Act which laid the foundation for a universal health care system. New Zealand became the first country in the world to develop a public hospital service as part of its welfare state, and the State assumed responsibility for funding a range of other health care services, beginning with maternity care and family doctor care. The range of services eligible for full or partial funding by government steadily increased until " by 1947, the thrust to put a universal and predominantly tax funded public health system into place was largely completed, although new subsidies continued to be added on an ad hoc basis" (Ashton, 1992, p. 148).

With broad recognition that the State had a responsibility to provide a range of health services for New Zealanders on the basis of need, the New Zealand public health system continued to function and expand without major change until the early 1970s. The last three decades, however, have been marked by repeated reviews, reports and policy statements on the direction of the New Zealand health system, which have led to significant legislative changes and several rounds of major restructuring.

The first suggestion of change in this period was outlined in the White Paper " *A Health Service for New Zealand*" (1974), commissioned by the Labour Government of the time. The White Paper proposed the amalgamation of small hospital boards into 14 regional health authorities which would be responsible for comprehensive health services, and although this recommendation did not

find immediate favour, it was eventually effected in the Area Health Boards Act (1983). The report also recommended greater integration of primary, specialist, secondary and rehabilitative care and the closure of single service hospitals (e.g. maternity and psychiatric).

The year of 1974 also saw the introduction of the Accident Compensation Commission (ACC) which was to have the function of administering a public accident insurance fund. Compensation for accident victims was to include full medical costs, 80% of lost earnings, and lump-sum compensations for permanent disability. The fund had three contributing components: levies on employers to cover both work and non work related accidents of employees, levies on motor vehicles to cover all motor vehicle accidents, and the government's own contribution to cover the costs of non working New Zealanders (Borren and Maynard, 1993, p. 4).

In 1978 the integrated services concept which had first been proposed in the 1974 White Paper was pre-tested in the form of the Northland Area Health Board pilot. Five years later the Area Health Boards Act (1983) laid the framework for all hospital boards to move towards integrated Area Health Boards. Area Health Boards (AHBs) were elected, and boards were empowered to appoint Community Committees as a means of improving communication with community groups working in the health field. The 1983 legislation also introduced the concept of capped population-based funding - a major departure from the open-ended state commitment to health care funding which had been mandated by the 1938 Social Security Act.

The framework established by the Area Health Boards Act, however, was to have a limited time span. In the six years between the passage of the Act and the full network of 14 Area Health Boards being established, two major reviews of the health sector were undertaken. The first of these, the Health Benefits Review (1986) was commissioned by the Labour Government to report on the underlying rationale for state involvement in health and to recommend broad principles and directions for reform (Scott, Fougere and Marwick, 1986). It began with the assumption that ideas which had been part of the New Zealand welfare state for nearly 50 years could no longer be taken for granted, and outlined five broad possible options for the future of the New Zealand health sector. The review committee's preferred options were either a system with competitive Health Maintenance Organisations or one involving the state as principal funder contracting for some services. It was acknowledged that a completely competitive Health Maintenance Organisation option would be too abrupt a departure from the hitherto publicly dominated system to be comfortably accommodated by New Zealanders. The conclusion therefore was that it would be best for the State to continue in a strengthened role as the main funder of health care, providing some services directly and contracting with providers for a range of other services.

The concept of ensuring the provision of services for users by means of contracting with providers was proposed far more unequivocally in the second major review of the health system commissioned in the 1980s. The Hospital and Related Services Taskforce produced a report entitled "*Unshackling the Hospitals*" (Gibbs, Fraser and Scott, 1988) which received considerable attention from the public and the lay press. Working from the premise that the main problem in New Zealand hospitals was poor management due to both insufficient relevant information and appropriate incentives to use it, the Gibbs Report (as it became known) recommended separating the funder and provider roles primarily through the establishment of six Regional Health Authorities (RHAs) which would purchase services on behalf of their constituent populations. "They would not manage or own any services but would contract with public, private and voluntary providers on a competitively neutral basis." (Gibbs et al., 1988, p. 27). Providers would be paid for pre-specified treatments rather than "what they spent". Under this system the Ministry of Health would deal solely with policy advice to the Minister. The Taskforce provided specific recommendations for the implementation of their proposed system complete with a detailed timetable that would see the system fully operational by April 1992.

However, as had been the case following the 1974 publication of the White Paper, the Labour Government of the time chose to implement far less radical reforms than those proposed in the Gibbs Report. It adopted the Taskforce's suggestion that the old system of hospital management by a triumvirate consisting of a nurse, a doctor, and an administrator be abolished and replaced by a general management model. The Labour Government chose to stay with the recently established Area Health Boards rather than disestablishing them to make way for a completely new purchasing structure based around Regional Health Authorities. By 1989 the full network of 14 Area Health Boards was in place and under the New Zealand Health Charter each AHB was required to sign a performance oriented accountability agreement with the Minister (Blank, 1994). The New Zealand Health Care Charter set out the following principles which providers were expected to adopt:

- respect for individual dignity
- equity of access
- community involvement
- disease prevention and health promotion
- effective resource use.

In addition the Charter identified ten health goals which addressed important causes of death, disease or chronic disability, and targets for each were established for the year 2000.

Although the Gibbs Report was rejected by the Labour Government which had commissioned it, it was to form the basis of the health care reform package of the incoming National Government in 1990. In 1991 the new Minister of Health, Simon Upton, released the Green and White Paper "*Your Health and the Public Health. A Statement of Government Health Policy*," which outlined a programme of major change. The paper identified eight significant problems with the previous health system. These were:

- public hospital waiting times too long
- fragmented funding
- problems with access to services
- lack of assistance for doctors making decisions
- lack of consumer control
- constraints on Area Health Boards to change services
- conflict in dual roles of purchasers and providers
- lack of equity.

By way of answer to these problems, the Green and White Paper advanced the concept of the split between the purchasers of health care services and those who provide them. Elected Area Health Boards were abolished and four instead of the six Regional Health Authorities suggested by the Gibbs report were established and given the task of purchasing both primary and secondary health care services on behalf of New Zealanders. Public hospitals were reconfigured as Crown Health Enterprises (CHEs) which were to be run along business lines under the direction of appointed Boards of Directors. CHEs and other provider organisations were dependent on contractual arrangements with the RHAs in order to access a share of the tax-payer supplied public health fund (Vote: Health). A National Advisory Committee on Core Health and Disability Services was established and charged with the difficult task of defining the "core" - i.e. health services to which every New Zealander could be guaranteed access within a reasonable period of time.

Some aspects of Upton's original vision however did not endure. Initial plans allowed for the creation of alternative health care plans which would compete with RHAs for the right to purchase health services on behalf of clientele. Under this system New Zealanders could have withdrawn their personal annual entitlement to public funding from the relevant RHA and transferred it to an alternative purchaser. This plan met with considerable counter pressure from the outset and was abandoned well in advance of its projected start up date in 1994. Two other parts of the reform package were implemented for a short period before being abandoned. User part charges for hospital care were introduced initially but later dropped due to public hostility and non-compliance.

A Public Health Commission was originally established to co-ordinate and purchase public health services but this was disbanded early in 1995, and its functions incorporated into the Ministry of Health, and later the Health Funding Authority (HFA). Following the abolition of the Health Funding Authority in 2000, its functions were returned to the Ministry of Health.

Meanwhile, health workers and consumers alike continued to grapple with the realities of the reform package that endured, mainly in the form of the split between purchasers and providers. The nature of these reforms, centred on the purchaser - provider divide, was similar to changes introduced in the Netherlands, the UK, Sweden, Israel and Russia (Borren and Maynard, 1993). The move to a purchaser - provider split has been a common response by governments in the Western world to the problem of burgeoning health care demands, due in a large part to medical and pharmacological advances and a static or shrinking public health care budget (Blank, 1994).

However, the incoming Labour Government in 1999 heralded a fresh round of structural reform in the health sector as one of its flagship policies. The stated intent was to design a system which would achieve greater responsiveness to local communities. The New Zealand Public Health and Disability Act 2000 therefore replaced the transparent purchaser – provider split with a new structure based on 21 locally elected District Health Boards (DHBs), charged with the responsibility of both funding and providing a comprehensive range of public health services for their respective populations.

2.3 The Recent Context for Maternity Services in New Zealand

While the New Zealand health care sector overall has been characterised by major upheaval in recent decades, the maternity services environment has been an acutely affected microcosm of the general pattern of change. These changes have sometimes been the direct result of a general legislative package, and sometimes they have developed from the internal momentum of the maternity environment itself.

Maternity services were affected dramatically by the sweeping changes of the 1938 Social Security Act. With the passage of this Act maternity care became available free of charge to all New Zealand women, and maternity service provision became a more reliably lucrative option for health professionals. A period of legislative stability for maternity services as well as the health sector in general followed, until the early 1970s. Changes of a different nature, however, were taking place. Both Donely (1986) and Fleming (1995) discuss the gradual erosion of the practice of midwifery in New Zealand accompanied by the progressive medicalisation of childbirth during this period.

As momentum gathered for major reviews of the public health system in the early 1970s, maternity services entered an era of legislative, public and media attention that would continue to intensify over the next three decades. This period commenced with the Nurses Act (1971) which required all births to be supervised by a medical practitioner. Fleming (1995) notes that the enactment of this legislation meant that the status of midwives became indistinguishable from that of obstetric nurses. Further restrictions for midwives followed in 1975 with the release of the Obstetric Regulations. This set of rules, devised by the Maternity Services Committee, laid down precise and lengthy regulations for procedures and documentation for birth and the postpartum period. Many of the provisions in the 1975 regulations were revoked in the 1986 version which simply stated that many of the previous regulations were "best left to good professional practice or administrative instructions" (Maternity Services Committee, 1986, p. 6).

In 1983 a pivotal legislative event occurred. The 1983 Amendment to the Nurses Act prohibited midwives, who were not also registered nurses, from attending births in "any place other than an institution under the control of an Area Health Board or Hospital Board" (Amendment to the Nurses Act, 1983, p. 10). With the exception of direct entry midwives already in domiciliary midwifery practice, midwives who were not also registered nurses could now only practise in hospitals where supervision was deemed to be adequate (Fleming, 1995). At the same time the Act enabled any registered nurse to carry out or supervise "obstetric nursing". Midwifery as a separate profession was now critically compromised. Writing in 1986, Joan Donely voiced the following opinions: "Today New Zealand's maternity services are a shambles. Women are fighting to reclaim their bodies, their babies and their birth experiences; midwives are struggling to regain their profession. In 1937 and 1951 women stood at similar crossroads in relation to maternity services. On both those occasions because they did not understand how those services had developed, they were manipulated and subverted in the interests of others" (Donely, 1986, p. 121). The 1983 legislation had however effected a turning point. Throughout the mid to late 80s hospital and domiciliary midwives united and were supported by consumers in their struggle to save midwifery as a profession in its own right.

By August 1988 they had made considerable headway. The NZ College of Midwives (NZCOM) was officially launched, and midwives and consumers continued to lobby for direct entry midwifery education. In 1989 this positive momentum was apparent in the wider climate. The discussion document "*Care in Pregnancy and Childbirth*" was issued by the Department of Health in 1989. This document acknowledged that pregnancy and childbirth were part of the normal life experience of women and made a first attempt at establishing national guidelines for the development of policy for low risk pregnancy.

In 1990 a new amendment was made to the Nurses Act which would have far reaching consequences for the future of maternity services in New Zealand. The 1990 Amendment revoked the 1971 Nurses Act, restoring to midwives the opportunity to practise independently and in doing so providing birthing choices for New Zealand women. The legislative change also made it possible for midwives to claim fees from the Maternity Benefit Schedule at the same rate as medical practitioners. This payment provision, a long overdue implementation of equal pay for work of equal value, fuelled some acrimonious debate amongst the community of health professionals involved in maternity care. It also meant that because both a midwife and a general practitioner could claim for the same client, the maternity benefit by necessity expanded to accommodate this.

In 1992 Simon Upton, the then Minister of Health established the five-member Maternity Benefits Tribunal to reconsider maternity fee structures. Previously tribunals had been attended only by the New Zealand Medical Association (NZMA) and the Department of Health. The 1990 legislation made NZCOM a party to the negotiations. NZMA argued for two separate schedules for doctors and midwives but the principle of one schedule was upheld. The tribunal's recommendations, however, had they been adopted, would have benefited doctors more than midwives as the base consultation fee was to be increased by 26% to \$26, while the conduct of labour fee was to be reduced from \$139.60 to \$52 an hour. The new Minister of Health, Bill Birch, adjusted these recommendations after seeking further input. The base fee rise was reduced to 10% and NZCOM's opinion in favour of a conduct of labour rate at four times the base fee was adopted.

A far more consequential reconsideration of the Maternity Benefit Schedule which is the focus of the work of this thesis, began in 1993, and culminated in July 1996 with the issuing of a new *Notice* concerning the provision of maternity services under Section 51 of the Health and Disability Services Act (1993). The new *Notice* was built on the concept of a lead maternity carer (LMC) who would be nominated by the woman receiving care. The vision articulated by the joint RHA maternity committee was as follows:

- *The prime focus of maternity services will be the woman, baby and her family or whanau and their identified needs as they relate to pregnancy birth and parenting.*
- *The quality of the services provided and the safety of the mother and baby will be paramount, including cultural safety for all women and particularly for Maori women and their whanau.*
- *The RHAs also wish to ensure that all women are provided with appropriate information about the options that are available to them*

concerning health professional services available, place of birth and services they are entitled to receive.

- *A Lead Maternity Carer chosen by the woman with responsibility for assessment of her needs, planning her care with her and the care of her baby and being responsible for ensuring provision of maternity services, will be the cornerstone of future maternity care in New Zealand.*
- *The RHA expects the Lead Maternity Carer to ensure good co-ordination of care including continuity of carers and referral to support groups, community agencies and other health care services.*
- *The RHA wishes to see more emphasis on health education, understanding the options for planned parenthood and promoting good health care in pregnancy and following birth particularly for women and babies at risk of adverse outcomes, e.g. postnatal depression, poor parenting, low birth weight babies.*
- *In order to ensure ongoing improvements in care, there will be an emphasis on information requirements to monitor both cost and effectiveness of services using mechanisms that will allow both consumers and providers to review the delivery and effectiveness of maternity services in an informed way.*

(Notice Issued Pursuant to Section 51 of the Health and Disability Services Act 1993 Concerning the Provision of Maternity Services, 1996, p.3)

As part of the new structure, each woman was required to sign a registration form to validate the lead maternity carer of her choice, who then had the right to claim fees for providing maternity care on her behalf. Lead maternity carers, who can be either midwives, general practitioners or obstetricians have overall clinical responsibility for the primary maternity care of the woman who nominated them. The new *Notice* introduced comprehensive service specifications for primary maternity care which reinforced the need for the LMC to involve the woman in planning and managing her care (Health Funding Authority, 2000b). When the changes were introduced the RHAs envisaged that women would choose their lead maternity carers at around 12 weeks of pregnancy, with the *proviso* that they could change their LMC at any time if they wished. In theory a woman could choose a midwife, a doctor, a specialist or a CHE team to act as her LMC, although in practice this choice was sometimes limited by either a pregnancy with complications (requiring a specialist LMC) or simply the limited availability of health professionals in her area.

Prior to 1996, claims were made for each individual item of service such as an antenatal visit, a postnatal visit or attendance at the birth. Attendance at labour was paid on an hourly rate.

Providers of maternity care now claim under a modular system whereby portions of care are block funded. The modules specified in the 1996 *Notice* are as follows:

- Registration with the Lead Maternity Carer and Care Plan Development
- Pregnancy Care in the Second Trimester
- Pregnancy Care in the Third Trimester
- Labour and Birth Services
- Services Following Birth

There is a set fee for each of these modules, which is paid to the lead maternity carer. The *Notice* outlines service specifications and a payment schedule for each module as well as for a number of 'single service episodes' which are paid for on a fee for service basis (for example, pregnancy care in the first trimester, before a woman has nominated her lead maternity carer). For an urban women giving birth in hospital the LMC receives a total of \$1500 - \$1800 for the modules outlined above. Additional fees are claimable for specified 'single service episodes' and a range of other categories such as 'Supplies and Services for Home Birth' and the 'Rural Home Visit Travel Supplement.' The LMC is not required to hold the budget for laboratory tests, pharmaceuticals, specialist or other secondary services.

One of the first changes encountered by women following implementation of the new framework was the reduced availability of a care arrangement which had become known as 'shared care.' This option for care delivery had been available to New Zealand women for six years and had become increasingly popular during that time. Women opting for this arrangement received care from a general practitioner and from a midwife providing continuity of care (e.g. a midwife who would be involved in the ante and postnatal phases and who would in most cases attend the entire labour and birth from the point at which the woman went to hospital or requested the midwife's assistance at home).

Since the enactment of the Nurses Amendment Act in 1990 and prior to July 1996 both midwives and doctors were eligible to claim a birth fee (\$315). In cases where either an independent midwife or a doctor attended the birth, only one fee was payable. In a shared care arrangement, where both attended the birth, two birth fees were claimed. The birth fee included two hours attendance at the labour, and attendance beyond this time was paid on an hourly rate. The 1996 *Notice* priced the Labour and Birth Services Module at \$950 for a first birth and \$750 for a subsequent birth. The module fee was payable to the health professional whom the woman had elected to have as her LMC. If a second health professional was involved in providing primary maternity care for the same woman it was expected that an agreement would be reached

between the two health professionals regarding how to split the fee. Many health professionals claimed that there was now not enough money to pay two health professionals and /or that the fee splitting negotiation would be too difficult or too time consuming. It was for these reasons that women found increasingly that health professionals were no longer offering a shared care arrangement as an option. [

The *Notice* was amended in 1998 with the key change being separation of the fee for doctor LMCs using hospital midwifery support services. The *Notice* requires midwifery input in every labour and birth and postnatal period. Prior to the 1998 change, this meant that doctor LMCs needed to formalise subcontractual arrangements with midwives, defining the components of service that each would provide and setting a price for the services. However, subcontracts were not generally developed even though Health Benefits Limited (HBL) had the capability to make these payments on behalf of practitioners. Prior to the 1998 amendment, many doctors claimed the full LMC fee and hospitals provided doctors with midwifery support services for no payment. Other significant changes included the removal of ultrasounds from LMC budgetholding and the removal of the 'options of care' fee where practitioners had been paid a \$10 fee for providing women with unbiased information prior to registering an LMC. This was replaced with a national freephone information service

2.4 Consumer Involvement

There is considerable potential for consumers of maternity services in New Zealand to play a participative role in the provision of those services. Scope for consumer involvement exists at a number of levels, the first of which is the individual partnership between a maternity client and her lead maternity carer. This partnership, which is a model for other organisational and structural partnerships which exist within in the maternity services arena, has its basis in the recognition of the power dynamics relevant to relationships between maternity clients and health professionals. The ideal partnership is based on shared information and joint decision-making and leads to well grounded informed choice and informed consent. It flourishes most often in the supportive environment of continuous care from one health professional. Beyond the scope of the individualised episode of care there are two other broad categories of consumer involvement in the field of maternity services: lobbying activities, and the structural integration of consumers into the planning, management and evaluation of maternity services.

One of the key ways of influencing the direction of maternity services in New Zealand has traditionally been to join one of the consumer groups, which exist to provide support for maternity service consumers and to lobby on their behalf. New Zealand's longest standing consumer group,

Parents Centre, started in 1951 as the Natural Childbirth Association, but changed its name six months out from establishment because the words "natural childbirth" fuelled considerable antagonism from the medical establishment of the time. The original aims of Parents Centre included the promotion of education for childbirth, rooming in, breastfeeding and birth at home (Dobbie, 1990). By the 60s their focus had altered and Parents Centre groups were no longer providing active support for the homebirth option, but members lobbied effectively for changes within the hospital walls such as rooming in and the acceptance of demand feeding.

Momentum for more far reaching change was gathering from a number of sources throughout the 1970s. The community health movement and the women's health movement were both vocal and organised during this time. The issues raised by the two health movements included demands for more accountability, more participation in decision making and increased responsibility for health by the recipients of health care, the provision of more information and increased discussion of legal and ethical concerns.

These key influences of the 1970s ushered in a new lobbying and support group which was based on a strong collective partnership between domiciliary midwives and birthing women, and which offered a far more radical critique of the medical establishment in relation to childbirth. The Auckland Home Birth Association was established in 1978, and other parallel associations throughout New Zealand quickly followed. This set the scene for an eventful period of consumer engagement with maternity issues. One of the first actions of the Home Birth Association (HBA) was to lobby for an increase in the domiciliary midwives' fee which was at the time sufficiently low to prevent many potential domiciliary midwives from taking up practice. Consumers wrote submissions, sent letters to the Minister of Health, met with local MPs and organised a public protest march. Their efforts did not go unnoticed. The 1986 Health Benefits Review Committee commented on the large number of submissions it received about home birth and domiciliary midwives and recognised the growing influence of the vocal home birth movement which had taken up the cause of domiciliary midwives (Scott, Fougere, and Marwick, 1986). Also in 1986 Manawatu HBA member Jean Kennedy attended a Labour Party Policy Conference and successfully lobbied for two remits. The first of these outlined the need for direct entry midwifery training in New Zealand; the second urged support for the home birth option by paying domiciliary midwives at least to the level of their hospital colleagues.

A third lobbying group, the Save the Midwives Association, was formed as a direct response to the 1983 Nurses Amendment Bill. Once again the group's philosophical basis derived from a partnership between midwives and women. (Guilliland and Pairman 1994, Pairman 1996). Regular newsletters were sent to members encouraging them to lobby women's groups, who in turn took up

the cause of midwifery and lobbied members of parliament. The Home Birth Association also lobbied on these issues as there was considerable overlap in the membership of both groups. More than 230 submissions were received by the select committee on the 1983 Nurses Amendment Bill. Successful lobbying had created a groundswell of support, and opposition to the Bill attracted sympathetic media attention. Some changes were effected and Save the Midwives went on to promote direct entry training for midwives in New Zealand. By this stage the lobbying partnerships between women and midwives had reached a sufficient critical mass for a new kind of partnership to emerge: a structural partnership between consumers and midwives.

This was first evidenced in the establishment of the New Zealand College of Midwives (1989). Consumer representatives were included in the executive of the newly formed College, despite the fact that this was initially regarded unfavourably by the International Confederation of Midwives. The New Zealand College of Midwives, recognising the support base which had been so instrumental in effecting positive change for New Zealand midwives, maintained its stance on consumer representation in spite of international criticism. This form of partnership was here to stay and others would soon follow.

Domiciliary Midwives Standards Review Committees (DMSRCs) were first established in 1989. Both the medical and nursing professions had been urging for more stringent monitoring processes for domiciliary midwives, so domiciliary midwives pre-empted any plans that other groups might have had by establishing their own monitoring system - one that would include the consumer (Donely, 1993). The 1988 Cartwright Inquiry into the treatment of cervical cancer at National Women's Hospital raised issues pertaining to patients' rights and informed consent at a national level. By including consumers in the DMSRC process, domiciliary midwives were in the vanguard and on course with the Cartwright Inquiry which was recommending quality assurance programmes which involved patients. DMSRCs were set up throughout the country with an equal ratio of consumers to health professionals. Structural partnerships were beginning to consolidate. The example of domiciliary midwives was later followed by DOMINO midwives (midwives who cared for women choosing to give birth in hospital and return home immediately afterwards), with the establishment of these new review committees being co-ordinated by NZCOM.

With the emergence of the College of Midwives consumers had become a formal party to one of the key stakeholders that influence maternity services policy development. The widespread establishment of Midwives Standards Review Committees has meant consumers are now equal partners in some of the structures which evaluate maternity services. There are also currently examples of maternity provider organisations which include consumers in their governance structures. In summary, the last three decades have seen a very significant increase in consumer

participation in maternity services development and delivery in New Zealand to the point where the partnership model is more advanced in maternity than in any other health service and has been more fully realised in New Zealand than in any other Western nation.

Chapter 3: Involving Consumers in Health Service Development A Review of the Literature

3.1 Introduction

The processes outlined in this thesis collectively form a model for maximising acceptability from the consumer's point of view when developing and implementing new ways of delivering services in the health sector. The model's planning phase consists of prospective consultation, baseline sampling of individual consumer perspectives and consumer representation during the detailed part of the decision making process. The evaluative phase is made up of retrospective consultation complemented with the comparative and review stages of the longitudinal sampling study which was commenced in the planning phase. The following review of literature provides a rationale for the focus and design of the model and the selection of its components with a particular emphasis on the literature pertaining to maternity services.

3.2 A Consumer Focus

The people have a right and duty to participate individually and collectively in the planning and implementation of their health care.
-Alma Ata World Charter, World Health Organisation (1978)

The right of consumers and communities to participate in decision making related to health services has been a defining feature of recent decades. Rifkin, Muller and Bichmann (1988) identify three characteristics which are common to a wide range of definitions of the term "participation." The first is that participation must be active. The implication is that simply receiving services does not constitute participation. The second is that participation involves choice. Participation implies the right and responsibility of people to make choices and therefore, explicitly or implicitly, to have power over decisions which affect their lives. The third is that the choice must have the possibility of being effective. This suggests that mechanisms are in place or created to allow the choice to be implemented.

The literature on participation in relation to health service planning and evaluation covers a broad continuum which is inclusive of the terms "consumer" and "community." The term "consumer" refers to an individual health service user and spans a discourse on empowerment which ranges from the micro level of information sharing and decision making in the relationship between an individual and his or her health professional, to the macro level of collective consumer involvement in planning, evaluation and priority setting. The term

“community” generally refers to groups which share a common identity whether or not this includes a geographical association. It is particularly applicable to health programmes with a strong focus on community development and the wider determinants of health.

The democratic rights and concomitant duties of health care consumers and communities in relation to planning and evaluating health care services are discussed extensively in the recent literature (for example, Potter, 1988; Bjaras, Haglund and Rifkin, 1991; Morgan, Everett and Hawley, 1992; Simpson, 1993; Shackley and Ryan 1994, Lupton and Taylor, 1995; Anderson, 1996; Draper, 1997; Mullen 1999, Williamson 1999).

However, Blank (1994) sounds the following note of warning:

...health policy is distinctive because of the critical role of the medical profession in shaping and constraining it – a role without counterpart in other policy areas (Palmer and Short, 1989). Because of the centrality of health professionals, any successful policy must have their passive if not their active approval. Furthermore, since medical professionals largely determine the health care market, any attempts by government to control it risk condemnation from these key stakeholders. (p. 2)

A shift in the balance of power between stakeholders in the health sector is nonetheless becoming increasingly evident as consumers gain more influence in service design and delivery. The vision described at Alma Ata has taken hold despite the difficulties and complexities of power relationships within the sector. The resolve to realise this vision is, for example, evident in the following statement about consumer participation in health service planning by a consumer representative from Illawarra, New South Wales:

It is not the answer to all problems. It does provide information to all parties to help find the solutions to broader problems.... It is not a small, or lightly undertaken commitment. It does require a significant contribution of time and integrity.... It is not easy. It is not only worthwhile, but crucial that consumers are involved in health service planning. (Cited in Draper, 1997, p. 55)

The reference above to finding solutions to broader problems touches on one aspect of consumer participation which will become increasingly important as the tensions between heightened public expectations associated with increasing technological competency and a finite public health services budget become more apparent. As rationing and prioritisation by necessity become more overt, decisions taken in such an environment need to be made within a context of a genuine exchange of information and opinions between service users, planners and providers. The community can be – and needs to be – part of the solution, not part of the problem (Simpson, 1993).

With a view to assessing the degree to which communities are enabled and empowered to be a part of the solution, Rifkin et al (1988) formulated a series of five key process indicators for assessing community participation in locally based health programmes. The framework is designed to be applied both at the outset of a new initiative and then continuously over time. The five indicators encompass needs assessment, leadership, organisation, resource mobilisation, and management. Each of these headings has a related cluster of questions which guide an assessment of the processes of participation in specific health programmes. The development of such a tool is based on the premise underlying the Alma Ata Declaration that participation is both an end in itself and a means to the end of improved health outcomes.

Several other commentators have discussed both the intrinsic and applied benefits of community or consumer participation. Dwyer (1989), for example, cites legitimisation and compliance as specific benefits that make consumer participation worthwhile, and also notes that the process lifts the standard of decision making and has intrinsic and redistributive benefits. Consumer participation, when undertaken as part of a cohesive service planning strategy, will improve the quality and efficiency of health care and ensure the relevance of services to their users (Lupton and Taylor, 1995; Nuthall, 1996; Draper, 1997; Slack, 2000).

A consumer focus is both appropriate and essential for health services planning generally, but it is worth noting that a consumer focus is particularly relevant and achievable where maternity services are concerned. Maternity services are a high volume health service, experienced directly by a large cross section of the population. For most service users the maternity episode is a normal, if momentous life event, rather than an illness, as is recognised in the UK Maternity Service Committee's position on maternity care (1984):

Maternity care is exceptional in the Health Service insofar as the large majority of those for whom the care is provided are healthy women who come into hospital not to be treated or cured like a patient but to be assisted in a natural physiological process which for most of them is among the most important events of their lives.
(cited in Garcia, 1993, p. 1)

Given the overriding importance of events which maternity services are designed to support, it is unsurprising that numerous maternity consumer groups and networks, providing support, information sharing, education, advocacy and lobbying are well established in New Zealand and other countries such as Australia, the UK, USA and Canada. This prevalence of established consumer groups within the community makes the task of seeking consumer input and participation more straightforward for health service planners.

In the case of the model presented in this thesis, the fact that an established network of maternity consumer groups existed in New Zealand was a significant factor in facilitating two components of the model – consultation and consumer representation.

3.3 Theories and Models

A range of views exist on the most appropriate role of the consumer in the context of a publicly funded health care system. In the past, attempts to elicit input have tended to position consumers in a fairly circumscribed manner, inviting reaction to particular services or in such formats as structured feedback forms and patient/client questionnaires (McGrath and Grant, 1992). More recently, initiatives to seek consumer feedback have proposed a broader and more active role for service users, consulting with them about their needs and wishes, not just their retrospective responses to receipt of particular services or resources (Aronson, 1993). This shift highlights the extent to which the term “consumer” has altered in recent years, particularly as it relates to users of public health services. Although the term originates from the market model, within the context of public health services it now carries associations with participatory activities which can equally apply to communities, citizens, and the public.

Tenbenschel and Gauld (2001) however, in a discussion of policy making approaches (summarised in Table 3.1 below), position the term “consumer” in such a way as to emphasise its market origins, in contrast to the positioning of the term “citizen”.

Table 3.1: Four models of policy analysis (Tenbenschel & Gauld, 2001)

	<i>Rationalist</i>	<i>Stakeholder</i>	<i>Participatory</i>	<i>Neo-liberal</i>
What should policy processes do?	solve problems	manage divergent interests and values	produce legitimate consent	allocate resources efficiently
What are acceptable methods of policy development?	setting clear objectives, analysing and evaluating evidence	negotiation, bargaining, brokerage, compromise	citizen participation, debate, dialogue	instituting and maintaining market-like mechanisms
What are threats to good policy?	lack/ ignorance of information, populism	centralised control	domination	monopolistic
Who are legitimate participants in policy process?	technical experts, public officials	stakeholders (interest groups, government agencies), 'policy brokers'	citizens, social movements	consumers
Whose participation should be minimised?	non-experts, sectional groups	intransigent policy actors	dominating agents	'vested interests', rent-seekers
Should those with policy expertise and experience be trusted over those without?	yes	yes	no	no
Should policy making be regarded as political?	no	yes	yes	no

McGrath and Grant (1992) apply the term "consumer" to a number of points on the participatory continuum, ranging from market driven to empowerment approaches to consumer involvement. These are summarised in Table 3.2 below. This framework clearly distinguishes the traditional approach from what is now more frequently viewed as the ideal model for consumer involvement.

Table 3.2: Consumer involvement framework (modified from McGrath & Grant, 1992)

<i>Model</i>	<i>Traditional</i>	<i>Participative</i>	
		<i>(Transitional)</i>	<i>(Ideal type)</i>
<i>Value position</i>	<i>Geared to informing, servicing</i>	<i>Geared to consumer involvement in order to receive information and advice</i>	<i>Geared to consumer involvement within a structure of accountability in order to service or empower</i>
<i>Level of involvement:</i>			
<i>Individual</i>	individual professional casework case conference caseload management strong reliance on carers' views professionals viewed as main source of expertise	assignment of key worker workload management at an inter-professional level efforts made to ascertain consumers' views	individual planning individual action plan or individual case management/ service brokerage citizen advocacy
<i>Service</i>	informal consultation with consumer/ voluntary sector groups	advisory committees (passive or partial use involvement) formal professional worker attachments to consumer/ voluntary sector groups	self advocacy user unions joint management committees quality action groups
<i>District/ county</i>	surveys public meetings	surveys public meetings	district/ county planning groups with consumer representatives voluntary sector/ user 'forums'

Beresford (1988) uses slightly different terminology to delineate three approaches for hearing the voice of the consumer: the market research, consumerist and democratic approaches. The first, the market research model, is essentially concerned with information and intelligence gathering. Underlying it is the idea that if service providers listen to what service users have to say, they are likely to be better equipped to provide efficient and appropriate services. The second is the consumerist approach which Beresford suggests is an extension of the market research model. Under this approach issues are reframed in terms of market preferences, consumer rights and product developments, echoing the language and conceptions of the market economy from which they have been borrowed. This echoes the neoliberal approach espoused by Tenbensen and Gauld (2001) (see Table 3.1). The third is the democratic approach. Here the concern is with enabling the involvement of service users so that they may have a greater say in and control over the services that are provided. This approach shares similarities with the ideal participative approach articulated by McGrath and Grant (1992) and the participatory approach outlined by Tenbensen and Gauld (2001). Because the philosophies underlying each of these three approaches differ, it is important for policy makers and funders to be transparent about

their intentions when they engage in any one of these approaches. Beresford notes the difference between the rhetoric on this topic and the reality:

So far in our discussion about the voice of the consumer in welfare, we have heard most rhetoric about the third - the democratic approach. Most interest seems to have been expressed in the new consumerism, and, generally, we have not got much beyond information gathering. (p 38)

This is a theme that Aronson (1993) picks up on in her examination of the development of long term care policies for elderly people in Ontario. Aronson's assertion is that participatory strategies employed by the Canadian government for this exercise elicited only particular kinds of information from consumers and did not live up to their democratizing promise. She draws attention to the "official language of participation":

In expressing their concerns, their satisfactions and their hopes, Canada's senior citizens guide us: they direct our steps and light our paths.... It is my... hope that older Canadians will continue to participate in matters of concern to them (Government of Canada, 1982, cited in Aronson, 1993;p. 369).

The practice that Aronson observed was quite different. Rather than tapping elderly people's perspectives and experiences, it tended to confine them to speaking of services and solutions in terms of professional and administrative structures. Also, despite claims that the government was open to input, the overall course of policy development was already firmly established; older people's contributions were sought at a late stage in the policy making process and invited only over particular questions of implementation.

However, there are also examples of applied models for consumer participation which have succeeded. For example, Parboosingh, Stachenko and Inhaber (1997) describe the application of a model for consumer participation at multiple levels in setting the agenda for research and policy development associated with the Canadian Breast Cancer Initiative.

The first major activity carried out under the Initiative was the National Forum on Breast Cancer, held in November 1993. Women affected by breast cancer were involved on the organising committee and on the various subcommittees and working groups developing background information and materials for the Forum. The Report on the Forum made numerous recommendations for action and research based on the discussions at the Forum and the involvement of women and families affected by breast cancer in all phases of the Initiative was strongly advocated.

The majority of Canadian Breast Cancer Initiative funding has been allocated to the Canadian Breast Cancer Research Initiative (CBCRI). Women affected by breast cancer are involved as members of the Management Committee of the CBRI and have been included in the review process for proposals submitted to the CBCRI. Women affected by breast cancer are also represented on each of the other committees of the Breast Cancer Initiative to give input and help set priorities. The five regional Breast Cancer Information Exchange projects have as their objective the development of networks of easily accessible information for women with breast cancer, their families, the public and professionals. Women affected by breast cancer constitute 50 percent of the membership of the advisory committees which provide direction to each project, and participate in the evaluation of whether the projects are meeting the needs of the local community and the target audience.

A key contributor to the success of the model described by Parboosingh et al is that consumer participation was facilitated through a number of mechanisms and at a number of levels. This multi-faceted approach to consumer participation is also a feature of the model proposed in this thesis.

3.4 Components of the Model Proposed in this Thesis

3.4.1 Consultation

Consultation is an essential activity for health service planners in New Zealand, as it is required by law. The model for consumer participation proposed in this thesis was operationalised within the legislative context provided by the Health and Disability Services Act (1993). The Act has two references to consultation:

Section 18 (4) Every Regional Health Authority to consult:

“in regard to its intentions relating to the purchase of services in accordance with Section 34.”

....

Section 34: Regional Health Authorities to consult:

Every RHA shall, in accordance with its Statements of Intent, on a regular basis consult in regard to its intentions relating to the purchase of services with such of the following as the authority considers appropriate (a) individuals and organisations from the communities served by it who receive or provide health services or disability services; (b) other persons including volunteers and private agencies, departments of State and territorial authorities.

Case law further defined the meaning of this clause to include any parties who had ‘legitimate expectations’ that they would be consulted (Health Funding Authority, 2000a).

Consultation is also a requirement in the current legal environment. The New Zealand Public Health and Disability Act (2000) includes specific directives relating to consultation:

Section 38 District strategic plans

(3) Before a District Health Board determines or makes a significant amendment to a district strategic plan, it must –

...

(b) prepare a draft plan or amendment and consult its resident population on that draft

....

Section 40 Consultation on proposed changes to annual plan

As soon as is reasonably practicable after proposing a significant change to policies, outputs, or funding for outputs stated in its most recent annual plan, a DHB must consult its resident population about the proposed change.

Additionally, the New Zealand Public Health and Disability Act requires District Health Boards to “foster community participation”:

Section 22 Objectives of DHBs

(1) Every DHB has the following objectives:

...

(h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services

The definition of consultation most frequently adopted by government organisations is that provided by Justice McGeechan in Wellington International Airport v Air New Zealand [1993]:

Consultation must be allowed sufficient time, and genuine effort must be made. It is to be a reality, not a charade. The concept is grasped most clearly by an approach in principle. To “consult” is not merely to tell or present. Nor, at the other extreme, is it to agree. Consultation does not necessarily involve negotiation toward an agreement, although the latter not uncommonly can follow, as the tendency in consultation is to seek at least consensus....

Consulting involves the statement of a proposal not yet finally decided upon, listening to what others have to say, considering their responses and then deciding what will be done.

Implicit in the concept is a requirement that the party consulted will be (or will be made) adequately informed so as to be able to make intelligent and useful responses. It is also implicit that the party obliged to consult, while quite entitled to have a working plan already in mind, must keep its mind open and be ready to change and even start afresh. Beyond that, there are no universal requirements as

to form. Any manner of oral or written interchange which allows adequate expression and consideration of views will suffice.

At a New Zealand Law Society seminar in 1993, Fardell and Scholtens submitted that the law identified four fundamental elements of consultation:

- the consultor must provide the consulted with reasonable information
- the consultor must give the consulted a reasonable opportunity to state their views
- the consultor must consider the consulted's views with an open mind
- the consultor may act if the consulted do not fully avail themselves of the opportunity for consultation (cited in Nuthall, 1996, p. 10)

The legal requirement for New Zealand health funding organisations to consult reflects international trends based on the numerous benefits that can be derived from well managed consultation processes. For example, the Health Funding Authority Consultation Obligations and Guidelines (2000a) noted that consultation contributed to the development of good public policy by assisting the Health Funding Authority to:

- *Gain the full picture, understand and identify different communities' needs and priorities.*
- *Provide opportunities for communities (geographical, professional and communities with common interests) to participate in the development of policy, strategic directions and to test new ideas.*
- *Enhance decision-making by receiving information, opinions and ideas – as well as feedback from communities which helps identify and avoid pitfalls.*

At the same time, consultation usually:

- *Builds positive relationships with consumers, providers and the wider community, encouraging co-operation, understanding, respect and support.*
- *Encourages stakeholders to “buy-in” to decisions made.*

And ultimately it should:

- *Ensure better health outcomes. (Health Funding Authority 2000, p. 5)*

In a similar vein, the Illawarra Area Health Service cites the following win/win benefits of consultation in its 1997 publication, *A Guide to Working with Consumers*:

For the Area Health Service:

- *higher quality services and projects*
- *higher profile for health services in the community*
- *better informed needs identification and planning*
- *broader support for health service activities*
- *fulfilment of Health Department criteria for consultation with stakeholders*
- *enhancement of quality assurance activities and approach*
- *greater accountability for public funds*
- *potential for development of better quality projects*
- *wider source of ideas about needs and issues*

For consumers:

- *opportunity to have a say about issues and needs in the community*
- *greater sense of influence over the health services they use*
- *opportunity to have positive input to local health activities (p. 6)*

On the other hand, the risks associated with doing consultation badly or failing to undertake consultation at all are high. Without a mandate for change, funding organisations risk legal and political challenges, negative media coverage, repeat requests for information and the likelihood of having to revisit decisions.

In New Zealand, Regional Health Authorities (RHAs) and other bodies with statutory responsibilities to consult have had decisions delayed, reviewed or overturned by courts on the grounds of failing to consult properly. Costs of not doing it right are very high – not only financially but in reputation, planning for health gain, staff time and resources (Nuthall, 1996).

The *Health Funding Authority Consultation Obligations and Guidelines* (2000a) cited the following three examples where health funding or provider organisations were found wanting:

In New Zealand Private Hospitals Association v Northern Regional Health Authority (Judgement of Blanchard J, 7 December 1994), the High Court considered that if the method of contracting with private hospitals was to change to an elaborate tendering procedure this had to be preceded by appropriate consultation.

In Bishop and Others v Central Regional Health Authority (Judgement of McGechan J, 11 July 1997), the Court emphasised that the RHA's consultation obligation was "in regard to its intentions relating to the purchase of services":

The statutory direction is not restricted to "policy" as opposed to "procedure." It does not mention the word "policy." The only requirement is that the matter be one 'relating' to the purchase of services. While Parliament would not have intended to include trivia, significant changes in practice as to payment, eligibility,

and availability – and pre-eminently, whether a payment in fact made in the past will continue – fall within that category.

In *Health Care Hawkes Bay, Central RHA and Attorney General v Napier City Council* (Judgement of Ellis J, 15 December 1994) the High Court made it clear that it was not up to the Crown Health Enterprise to subjectively decide whether it had released enough information about its regional hospital proposal to amalgamate Napier and Hastings services at the Hastings site. A period of thirty two days was also deemed to be too short for consultation on such a difficult topic, even taking into account the fact that a two week extension had been granted. Health Care Hawkes Bay was required to extend the consultation period by two months.

It is clearly important that health service providers and funders plan to include adequate and well managed consultation processes when making changes to health services. However, improvements in decision making and health gain can be further maximised if a wider range of tools which foster consumer participation are utilised. In the model described in this thesis, consultation is complemented by consumer representation and a consumer perception sampling frame.

3.4 2 Consumer representation

Consumer representation brings unique benefits because it helps to ensure that service planners and health professionals are held accountable and reminded of consumer concerns at the time and place where the detail of new decisions is discussed and debated. A consumer representative is a member of a committee, advisory group or working party who voices the consumer perspective and takes part in the decision making process on behalf of consumers. Consumer representatives are accountable to the organisation they represent and refer back to their constituency. However, there are inevitable limitations regarding the degree to which any individual can be “representative”, as is recognised in *Bringing in the Voice of Consumers*, produced by Adelaide Women’s and Children’s Hospital (1999):

When a community group provides a ‘representative’ for a committee, the community group, the individual and your committee must all be clear about who this person is representing. It is not possible to have one person representing all members of all communities. A community or consumer ‘representative’ can only hope to provide a view which is outside or from a non-professional perspective and to consult with a limited range of people.

Many consumer organisations and much consumer participation research suggests that in general you should appoint two representatives, rather than one to organisational committees.... The additional costs are marginal. The benefits

include a broader range of perspectives and most importantly the opportunity for representatives to gain from mutual support and to more quickly gain the additional confidence needed to speak out and contribute. (p. 38)

It is also important for planners to be aware of the pitfalls of assuming that a consumer perspective is already present in the decision making process simply because the existing professional contributors to the process are also service users. This somewhat common trap is clearly identified in *Improving Health Services through Consumer Participation*, a resource kit compiled by Consumer Focus Collaboration (2000):

Clinicians and administrators sometimes suggest that specific consumer input is not needed as they themselves are also consumers and can somehow put on their consumer hat to get this input. While empathy with consumer viewpoints should be encouraged, this argument fails to recognise competing perspectives, interests and degrees of influence. A provider is primarily driven by the interests and experiences he or she has and cannot have the perspective of a consumer who approaches the system from a user's perspective. (p. 118)

Both consultation and consumer representation rely on input from consumers who take a proactive approach to exercising their democratic rights where publicly funded health services are concerned. An ideal process for seeking consumer input will also include some method of directly approaching service users who are less likely to volunteer their views.

3.4.3 A sampling frame for consumer perceptions

As an adjunct to consultation and consumer representation, surveying and interviewing recent users of maternity services is a useful way of gaining an understanding of the quality and relevance to those services. Repeated sampling using the same survey instrument over an extended timeframe also allows comparisons to be made about service provision relating to discrete time periods. If a substantial change is planned to the way services are provided, it is particularly important to establish an adequate baseline for a longitudinal study prior to implementing the changes. Garcia (1993) notes however, that this crucial step is frequently omitted:

It is worth considering using ... questionnaires in the context of planned changes in care.... Evaluation of any changes must be planned in advance of the change so that the existing service can be described and then compared with the new one. Health service researchers are often asked to assess the impact of a change in care after it has taken place. This is unsatisfactory but understandable, because baseline studies take time and often the opportunity for change seems likely to pass. (p. 17)

The importance of understanding and measuring women's perceptions of maternity care is gaining increasing recognition (Oakley, 1983; Green, Coupland and Kitzinger, 1990; Wilcock, Kobayashi and Murray, 1997; Tinkler and Quinney, 1998). Oakley (1983) identifies three ways of assessing outcome for any obstetric practice. She lists the usual indicators (mortality and physical morbidity) and adds a third - psychosocial morbidity, which includes maternal postnatal depression; lack of maternal satisfaction with the childbirth experience; unhappiness in the mother, father or baby; developmental problems in the baby; difficulties in the mother-baby relationship; or difficulties in the mother-father relationship. As Tinkler and Quinney (1998) note, "...women's satisfaction with maternity care is ... an important outcome of pregnancy and childbirth which has profound implications for a woman's own future well-being, that of her child and the mother-baby relationship" (p. 31). The validity of measuring satisfaction with maternity services is affirmed by Green et al. (1990) who conducted work with identified individual components of dissatisfaction and demonstrated that expressions of dissatisfaction are not simply a reflection of a hard to please personality.

In addition to providing assessments of satisfaction with care from the point of view of service users, surveys can also supply information about the pattern and content of care that is not available from other records (Garcia, 1993). Several comparisons have been made of data obtained from medical records with those collected directly from women (see for example Cartwright and Smith, 1979; Joffe and Grisso, 1985; Martin, 1987; Githens, Glass, Sloan and Entman, 1993; Olsen, Shu, Ross, Pendergrass and Robinson, 1997). In general, findings indicate that agreement between the two sources is good. A recent study comparing maternal recall and medical records in relation to events during pregnancy, childbirth and early infancy found that accurate perinatal information can generally be obtained with a recall period as high as four to six years (Githens et al., 1993).

A purely quantitative survey tool does however, have a number of limitations. An early Dunedin based survey of consumer evaluations, undertaken as a joint venture by the Otago University Community Studies Centre (Shannon and Neill), La Leche League of Dunedin (Hood) and the Department of Paediatrics, University of Otago Medical School (Clarkson) highlighted some of these limitations. The 127 women taking part in the study were interviewed six weeks after the birth of their baby using a structured questionnaire. Hood, Clarkson, Shannon and Neill (1978) observed that one of the recurring themes of the findings was a high level of satisfaction with whatever service was provided. This was particularly true of consumer evaluations of antenatal classes. *"The degree of satisfaction with antenatal classes was independent of the type of class attended; this in spite of the marked differences in format, topic covered, and degree of husband involvement in the different classes offered"* (p. 4).

This observation from an early New Zealand study has been echoed in the international literature on patient satisfaction which has drawn attention to the tendency for surveys asking patients to evaluate medical care to elicit responses which indicate high levels of satisfaction (e.g., Locker & Dunt, 1987; Carr-Hill, 1992; Westbrook, 1993).

Brown and Lumley (1994) suggest therefore that the emphasis should be on uncovering variability in responses by, for example, including both global questions asking for overall ratings and more detailed questions asking about specific aspects of care; including questions which elicit responses in women's own words; and ensuring subgroups of respondents will be large enough to facilitate valid comparisons. Brown and Lumley also argue that despite the existence of a standardised scale for rating satisfaction with maternity care, which has been assessed for validity and reliability (Lomas, Dore, Enkin and Mitchell, 1987) the benefits of a locally developed tool are compelling:

Developing our own questionnaire enabled us to tailor the wording and focus of questions to the setting in which the survey was to be implemented, taking into account what we had learned ... from the consultative processes.... It also enabled us to include questions directly relevant to current policy debates, a strategy that has considerably increased the level of interest among service providers, programme-planners and policy-makers in the findings of the survey. (p. 273).

Face-to-face semi-structured interviewing is a useful way of finding out why questionnaires elicit certain types of responses as part of the broader process of accessing more in-depth information about consumer perceptions of health services. Consumer Focus Collaboration (2000) note in particular that less structured interviews yield opportunities for exploring underlying thinking patterns and ways of talking about health related issues which can assist those directly involved in health improvement activities.

McSherry (1986), in her study involving 48 Manawatu women with five month old babies, used interviewing as the main research tool, arguing that women in previous New Zealand studies had had difficulty responding to questions which were often tangential or inconsequential to their experience. Her semi-structured face to face interviews were designed to allow women themselves to define what was relevant and significant. McSherry's interviewing strategy, which aimed at a reciprocal relationship between interviewer and interviewee, was influenced by Oakley's (1981) criticisms of traditional interviewing practices which employed a hierarchical and often exploitive relationship between interviewer and interviewee. Oakley argued that this style of interviewing is especially counterproductive when the goal is the documentation of intimate details of women's lives.

3.5 Review of Findings of Maternity Services Consumer Perception Studies

One of the most recurrent themes in the literature relating to consumer satisfaction with maternity care is the importance women place on information (for example, see Jacoby, 1988; Green et al., 1990; Brown and Lumley, 1994; McKinley, 1994; Proctor, 1998) and the frequently inadequate provision of information by health care providers (Barbour, 1990; Rice and Naksook, 1998; Emslie, Campbell, Walker, Robertson and Campbell, 1999). McKinley (1994) identified information as the most significant predictor of overall obstetric patient satisfaction. An adequate supply of information is a crucial prerequisite for informed consent and lays the foundation for women to participate actively in decisions about the management of their care. Satisfaction is closely associated with informed participation in decision making about care (Seguin, Therrien, Champagne & Larouche, 1989; Brown and Lumley, 1994; Wilcock et al., 1996; Fraser, 1999) and good communication with care providers (Sullivan and Beeman, 1982; Berg, Lundgren, Hermansson and Wahlberg, 1996). In a review of twenty five years of literature about obstetric patient satisfaction in North America, Wilcock et al. (1996) found:

there is a clear thread that ties together most of the literature in the area of women's expectations in childbirth, and that is the notion of being involved in decision making. Although the specific topics in which women want to be involved vary widely, the topics all reflect a desire on the part of patients to have their views heard and respected (p. 41).

One tool that has proven useful for facilitating informed consent and participation in decision making is the birth plan or care plan (Morcos, Snart and Harley, 1989; Moore and Hooper 1995). Moore and Hopper (1995) reported that women found a birth plan increased their own understanding about the processes of labour and birth and the hospital options open to them, enabled them to express their needs and preferences, enhanced their confidence, and improved communication between themselves and staff.

Another factor which may facilitate the expression of needs and preferences for women is the presence of a support person. Bluff and Holloway (1994) note this point, but caution that frequently health professionals directly or inadvertently limit this function:

It would seem logical to suppose that anyone supporting the woman in labour, particularly her partner, would ensure that her wishes were respected. The partner would therefore be her advocate. This is true for some of the women at some times:

“When I just came in the morning he spoke up for me about Syntometrine. Please can we have the 15 to 20 minute break before it is given.” (R3)

However, when the midwife did give the Syntometrine immediately at the delivery the woman’s partner made no attempt to intervene. The informant explained this:

“You see, you don’t interfere with a professional unless you are really disagreeing and they seemed in control. He was more concerned about how I was feeling.” (R3)

Similar actions of partners were reported several times. (p. 162)

However, regardless of limitations in this regard, the presence of a support person has been found to be a strong positive predictor of positive perceptions of birth (Mercer, Hackley and Bostrom, 1983; Bramadat and Driedger, 1993).

Continuity of care provider is also associated positively with satisfaction (McCourt, Page, Hewison and Vail, 1998; Emslie et al., 1999; Fraser, 1999; McCourt and Pearce, 2000) and some studies have reported higher satisfaction for women provided with midwife-managed care (Shields et al., 1998; Tinkler and Quinney, 1998).

Intervention during intrapartum care has been associated with dissatisfaction. For example, Brown and Lumley (1994) reported that women were more likely to be dissatisfied if they experienced an emergency caesarean section; used pethidine, nitrous oxide or general anaesthesia; found the pain worse than anticipated; had a high obstetric intervention score; or could not hold the baby soon after birth. The authors also noted (ibid) that women who scored as potentially clinically depressed according to the Edinburgh Postnatal Depression Scale were more likely than women not scoring as depressed to have had an operative delivery and a higher weighted score for obstetric procedures. Hood et al.’s 1978 report also commented on intervention rates, noting that 29% of respondents requested pain relief and received it, but a further 47% were given pain relief without initiating a request. Episiotomies were performed in 75% of all births, but only 42 % of women who were assisted by midwives. Within this context it is worth noting that two recently conducted randomised controlled trials have indicated intervention rates for women whose main care provider is a midwife are lower than intervention rates for women whose main care provider is a medical practitioner (Harvey, Jarrell, Brant, Stainton and Rach, 1996; Turnbull et al. 1996).

In general, adequate provision of information and opportunities to participate in decision making have been identified as having a strong positive association with satisfaction for maternity consumers, while intervention has been found to have a negative association. Factors which may assist with information provision and facilitate participation in decision making and/or decrease the likelihood of intervention include: use of a care plan, the presence of a

support person, continuity of care provider, and for low risk women, midwife managed care provision.

3.6 Conclusions

There is strong contemporary recognition of the role of the consumer in decision making relating to health services provision. The literature identifies various mechanisms through which consumer views and requirements can be articulated.

This thesis proposes an ideal model for consumer participation in major service reconfigurations. The key elements of the model are: consultation; consumer representation on the decision making bodies that refine and agree service specifications; and quantitative and qualitative sampling of consumer perceptions both prior to and following implementation of the new service framework. This thesis describes how this model was operationalised, and evaluates its effectiveness.

Chapter 4: Prospective Consultation and Consumer Representation - Groundwork for the July 1996 Notice

4.1 Introduction

In the three year run up to the implementation of the new framework for primary maternity services two important aspects of the model presented here were in process. The first of these, consultation, was managed purposively and comprehensively by the funding authorities. The second, consumer representation at consumer negotiations concerning key aspects of the new framework was not arranged at the outset by the funding authorities. The New Zealand College of Midwives (NZCOM) however, introduced consumer representation to this forum by including a consumer as part of its own negotiating team.

4.2 Consultation

In 1993, the four Regional Health Authorities (RHAs) initiated a joint maternity project and began an extensive consultation process with providers and consumers. The consultation process was lengthy and iterative, beginning with the establishment of generic principles, progressing to the proposal of a tentative framework, and concluding with the refinement and consolidation of the detail in the framework.

As a significant early indication of the emphasis the RHAs would place on consumer participation in the planning process, the Northern Regional Health Authority contracted the Auckland Maternity Services Consumer Council (MSCC) to conduct a consultation process with its member groups in order to define quality indicators for Auckland maternity services.

MSCC was at that time made up of 78 community groups with an interest in maternity services provided in the Auckland region. Some member groups have an interest in the whole childbearing cycle (e.g. Auckland Women's Health Council, Parents Centre, National Council of Women) while others represent consumers who have a clearly defined area of need (e.g. Postnatal Distress Support Network, Miscarriage Support Group). Groups who represent a particular cultural perspective also form part of MSCC (e.g. Maori Women's Welfare League, Pacifica).

A working party consisting of five representatives from MSCC member groups developed a questionnaire and distributed it to all member groups for consideration and completion. To assist the process, MSCC held an open forum in July 1993 for its member groups. The resulting report *Quality Indicators for Auckland Maternity Services*, released in November 1993, identified a number of prevalent themes in the responses received (Auckland Maternity Services Consumer Council, 1993). These are summarised below:

- **Availability maternity care at no cost to consumers** (excepting circumstances where there is no medical indication, e.g. routine ultrasound scans)
- **Information and education.** A maternity service hotline and resource centres were suggested. There was also an expressed need for the publication of statistics and other information about maternity services so women are better able to make informed choices.
- **Continuity of care** was identified as being both the preferred approach for the maternity setting as well as being the approach most likely to produce the best outcomes.
- **Respect for rights/informed consent.** A policy of informed consent with access to patient advocates and interpreters was considered to be an essential part of any maternity service.
- **Consultation and consumer input.** There was a strong call for consumer representation on all committees and working parties involved in the planning, review and monitoring of maternity services, including areas of teaching and research. Contributors believed that a partnership approach is a safe and positive model on which to base maternity services.
- **Cultural safety.** Contributors wanted to see in-service training programmes set up to focus on biculturalism and cultural safety.
- **Flexibility.** Contributors wanted a range of services in a variety of settings and skilled practitioners/staff who are appropriately trained to deal with a range of maternity experiences (e.g. miscarriage, abortion, stillbirth, postnatal depression) in a culturally appropriate way.
- **Provision of services within the home and within the local community.** Contributors emphasised the need for medical and support services to be easy to access and available locally.
- **Holistic approach.** The wellness model that recognises birth as a normal process came through as a constant theme. An holistic approach was seen as one in which each woman's physical, emotional, psychological and spiritual needs were considered and her social situation was taken into account.
- **Validation of procedures.** There was considerable support of the need to validate and justify the use of interventions in maternity care. The routine

use of interventions during normal pregnancy and birth was not generally supported by women, although there was support for interventions proven to be of value, to be available to women with special needs.

- ***Co-ordination.*** *There was strong support for a co-ordinated approach to be applied to the provision of maternity services in order to improve consistency of information; access to services; efficiencies in the way services are provided; and the way in which research is conducted.*

In a similar vein, though with a nation-wide focus, Coopers and Lybrand were contracted to consult with users and providers to determine: the minimum requirements for maternity care; the quality standards associated with the components of care; possible options for the delivery of care; and the factors which should be taken into account when purchasing or providing care.

Coopers and Lybrand conducted a review of New Zealand and overseas literature, met with the Core Health Services Secretariat and studied material produced by various earlier reviews of maternity services to establish a baseline of issues. A summary of these issues, together with a discussion format based around ten key questions facilitated input from the parties Coopers and Lybrand met with. The consumer groups represented in the review process included the Federation of Women's Health Councils, Maori Women's Welfare League, Maternity Services Consumer Council, New Mothers Support Group, Post and Antenatal Depression Support Group, Home Birth Association, Maori Women's Homebirth Support Group, Women's Division of Federated Farmers, DPB (Domestic Purposes Benefit) Action, and Mothers Alone. A small number of individual consumers were met with who brought a perspective less frequently represented in the larger consumer groupings. Individual participants included a mother with a disability, a mother with a disabled child and a rural mother with eight children.

The subsequent report *First Steps Towards an Integrated Maternity Services Framework* (Coopers and Lybrand, 1993) was endorsed by the RHA Boards. It outlined an integrated modular framework for maternity care based on well-informed women choosing a lead professional. The report identified the following problems with the maternity system which was current at that time:

- fragmentation of funding
- fragmentation of care
- differing philosophies
- inequity of access
- lack of balanced information
- lack of balanced data

With respect to the problem fragmentation of care, the authors noted that everyone they met with was “unanimous in their support for the concept of continuity of care despite differences in the actual definition applied” (Coopers and Lybrand, 1993, p.11). The report responded to the problems outlined above with some 35 recommendations. A key characteristic of the proposed framework was the concept of a contracted principal practitioner for each individual, who would be responsible for ensuring that appropriate services would be delivered either by delivering them himself or herself, or by arranging with other providers to do so. The report authors noted that the main differences between the previous arrangements and those envisaged by the new integrated maternity services framework would be as follows:

- services defined to match the assessed needs of the woman, her baby and her partner/whanau/family rather than being limited to services covered by specific schedules and approaches
- services designed to focus on the achievement of quality outcomes rather than solely on the process of services delivery
- a focus on purchasing services rather than funding providers
- greater provision of information to inform consumer choice
- consumers, being better informed, play a greater role in service choice
- the framework offers greater continuity of care
- progress towards improving the match between assessed maternity service needs and the services actually received

The RHA maternity steering committee continued to work on the ‘integrated maternity services framework’ concept outlined in the report and retained the idea of a “contracted principal professional” who would assume responsibility for co-ordinating all aspects of a woman’s care. The four RHAs used the Coopers and Lybrand report as the basis for a joint RHA maternity strategy document which was consulted on extensively over the course of the next two years. Three specific aims for the Joint RHA Maternity Team’s consultation process are outlined in the Joint RHA Maternity Committee’s 1995 *Draft Report to the Ministry of Health Regarding Proposed Changes to Maternity Services*:

- *To create an environment between purchaser, provider and the public that would enable the concepts and decisions of the project to be achieved within the specified time frame by establishing a set of key messages, presenting these messages in such a way that they would be acceptable and effectively communicating the messages.*
- *To consult with community groups and with providers about proposed changes to maternity services and to invite comment and feedback about current issues and about proposed change and to invite suggestions for new arrangements.*

- *To increase awareness of provider and public as to costs involved and proposed methods of controlling these in such a way that providers would understand what was involved, and the public would have a better appreciation of the need for information about options and services. (p.2)*

Four successive drafts of the joint RHA strategy document were circulated to the key provider organisations and consumer groups. The consultation process involved 80 different organisations and 120 meetings. A number of focus groups were also held with new immigrants, very young women, Pacific Island women and women with disabilities.

Over 20 hui were held throughout Aotearoa to hear the views of Maori. Those who attended the hui included young mothers and grandmothers, educators, midwives, iwi representatives, health workers, sometimes partners and other relatives, as well as representatives from each regional health authority according to the location. The key issues identified included the importance of and need for more Maori to be involved as providers; a need for appropriate information; recognition that traditional Maori birth practices are being lost; and the need to clarify who can be a lead professional under the new arrangements (Joint RHA Maternity Committee, 1995).

In general those consulted with throughout this period were supportive of the core principles contained in the new strategy. The consultation process assisted with the refinement of the strategy and the addition of substantial detail to the generic principles first proposed in the Coopers and Lybrand (1993) report. At almost all consultation meetings, issues relating to information were raised. There was particular concern that information must be practical and culturally appropriate, easily available and independent. These concerns were partially addressed through the eventual provision (from 1998 onwards) of a nation-wide independent hotline and information kit about how to access maternity services, and the nature and quantity of services that women can reasonably expect from their maternity services provider. On another level, individual information and education needs were addressed through their inclusion in the individual care plan required under the service specifications. Women attending the consultation meetings identified the need for appropriate home support following the birth of their baby. This was an important issue for rural women, for women who were first time mothers, and for women with special needs. The expression of these concerns helped to shape the detail of the service specifications relating to the module covering services after birth. Women at hui said they were unhappy with the term “lead maternity professional” and this was subsequently changed to “lead maternity carer.” Women attending hui also noted that there was limited choice for Maori under the existing system with few, if any Maori providers. The joint RHA maternity team responded by incorporating the need for cultural awareness in the service specifications and making it possible for independent organisations like Maori groups to be

contracted to provide maternity services. A number of other concerns about quality issues influenced the considerable depth of detail in the final version of the service specifications.

The specific obligations of lead maternity carers are detailed in the *Notice*, including the requirement that they “make every effort to attend as necessary during labour and attend each birth.” This requirement sat well with the need for continuity of care that had emerged from consultation.

4.3 Consumer Representation

Each draft of the contracting strategy document was circulated to the New Zealand Medical Association (NZMA) and the New Zealand College of Midwives (NZCOM) and the RHA maternity team met with these groups to review each successive draft. As a result of these forums a number of critical changes were made to key aspects of the strategy document. The RHA maternity team did not seek representation of consumer groups at the meetings with NZMA and NZCOM where significant changes to the strategy were debated and agreed. NZCOM, however, included one consumer (the author) as part of its five member negotiating team. Although some benefit was derived from having a consumer voice present at the table where key changes to the detail of the strategy were negotiated, (for example, the final *Notice* quantifies the minimum number of postnatal home visits that must be provided for each woman) the overall process and outcomes could have benefited considerably from more comprehensive consumer representation at this particular forum.

At the prompting of the consumer brought to the process by NZCOM, the RHA maternity team eventually instigated a wider opportunity for consumer representation to assist with the evaluation of a proposal to amend the *Notice* received from NZMA and the New Zealand General Practitioner Association (NZGPA) four months after the 1996 *Notice* had been issued. However, by this time, the core opportunity for appropriate consumer representation had already elapsed.

This thesis presents the way in which the overall model evolved. Consumer representation at the critical juncture of negotiating and finalising the detail of the *Notice* is an area where there is scope for improvement in any subsequent applications of the model.

Chapter 5: Methodology for Consumer Perceptions Sampling

5.1 Introduction

A longitudinal sampling frame using a triangulated approach to data collection and analysis was employed to assess women's satisfaction with maternity services both prior to and post implementation of the new maternity services framework, thus providing a basis for comparison. The chief objectives were to ascertain whether or not women's satisfaction with maternity services changed following implementation of the new framework, and to identify particular aspects of service delivery where changing levels of satisfaction were evident.

Ethical approval for the research was obtained from the Massey University Human Ethics Committee and the relevant regionally based health ethics committees before data collection commenced. Regional approval was co-ordinated through the Manawatu – Wanganui Ethics Committee for the 1995 and 1997 data collection periods, and through the Auckland Ethics Committee for the 1999 national survey. Ethics Committee approval letters are reproduced in Appendix One. Approval to proceed with the 1995 and 1997 data collections was also obtained from the Chief Executive Officers of the Crown Health Enterprises within the Central region. My request for written approval was preceded by a letter about the study from the study funders, the Central Regional Health Authority, to the maternity managers of each CHE within the region, advising them of the forthcoming research project and requesting their assistance. Examples of this correspondence are reproduced in Appendix Two. The methods of distribution used for the 1995 and 1997 years required a closer relationship with the regional CHEs than was the case for the 1999 national survey. In 1995 and 1997 survey forms and interview invitation sheets were distributed chiefly by postnatal ward staff. For the 1999 survey a postal distribution direct to participants was used, based on data held by Health Benefits Limited.

Figure 5.1 below shows the geographical extent of the Central region. The CHEs and individual maternity units involved in the distribution of survey forms and interview invitations in 1995 and 1997 are listed in Table 5.1.

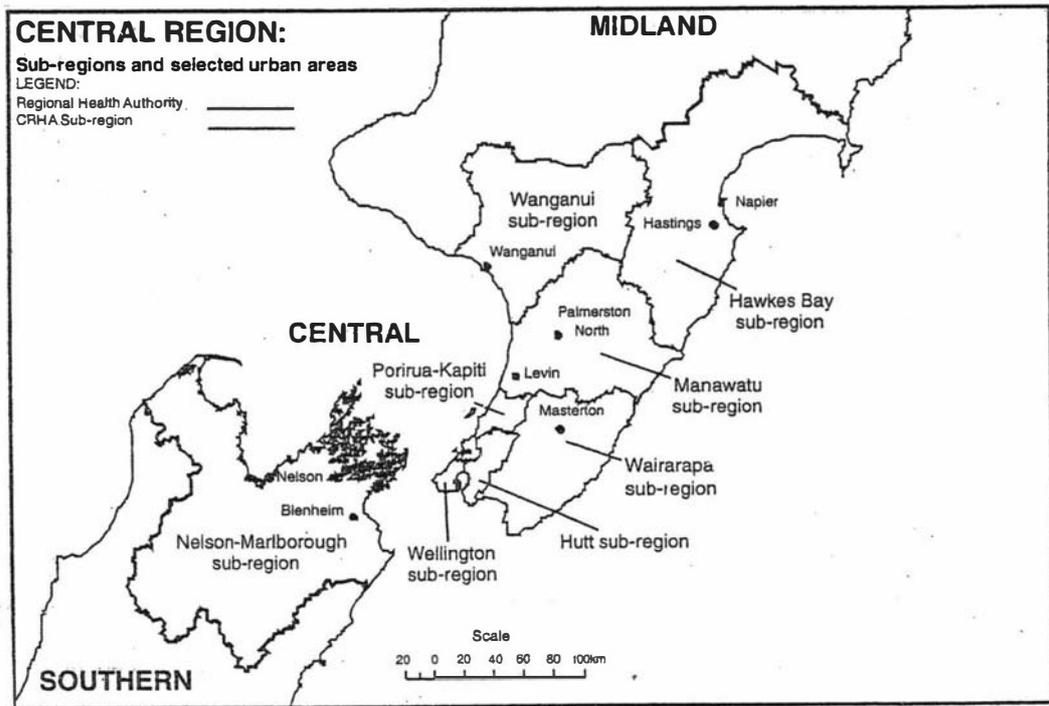


Figure 5.1: Geographical extent of the Central Region

5.2 Development of Research Instruments

A generic set of survey questions and sample questions to guide semi-structured interviews were originally developed with reference to the successes and limitations of previous New Zealand studies of consumer perceptions of maternity services (Salmond, 1975; Hood et al, 1978; Briggs and Allan, 1983; Society for Research on Women in New Zealand Inc., 1985; McSherry, 1986; Suckling, 1991; Research Solutions Ltd, 1994) and selected international examples (Bradley, Brewin and Duncan, 1983; Lomas, Dore, Enkin and Mitchell, 1987; Martin, 1987; Mason, 1989; Drew, Salmon and Webb, 1989 examples (Seguin, Therrien, Champagne and Larouche, 1989; Green, Coupland and Kitzinger, 1990; Jacoby and Cartwright, 1990; Mackey and Flanders Stepan, 1993; Bryanton, Fraser- Davey, and Sullivan, 1993; Brown, Lumley, Small and Astbury, 1994; Heaman, Robinson, Thompson and Helewa, 1994; Brown and Lumley, 1994; Bluff and Holloway, 1994; McKinley, 1994; Stamp and Crowther, 1994). The questions developed to guide the semi structured interviews are listed in Appendix Three.

Table 5.1: Maternity units involved in the 1995 and 1997 surveys.

Crown Health Enterprise	Units
Capital and Coast Health	Paraparaumu
	Paekakariki
	Porirua
	Wellington
Hutt Valley Health	Lower Hutt
Good Health Wanganui	Raetihi
	Taihape
	Wanganui
Hawkes Bay Health	Hastings
	Napier
	Wairoa
	Waipukurau
Mid-Central Health	Dannevirke
	Feilding
	Pahiatua
	Palmerston North
Nelson – Marlborough Health	Blenheim
	Motueka
	Nelson
Wairarapa Health	Masterton

The draft survey form was then pretested with a focus group of Maori new mothers and a focus group of non Maori new mothers. After modifications based on the feedback from this process, the survey was pretested further at Palmerston North Hospital. Approval was given by the manager of maternity services for the Mid Central CHE for this second pretesting exercise to take place. A staff member of the postnatal ward first checked with new mothers if they would be willing to assist with pretesting the survey form. I then introduced myself to each woman who agreed to take part, explained the objectives for the research and asked her to fill out a survey form. This was done on an individual basis with 12 women. In addition to the survey form itself, women were given a sheet with the following questions to facilitate feedback:

- *Are any of the questions hard to understand? Please tell me which ones.*
- *Do any of the questions seem inappropriate or offensive to you?*

- *Are there any questions that you think might seem inappropriate or offensive to someone else?*
- *Do you think I've missed out anything important?*
- *Any other comments?*

Women were encouraged to make notes on the survey form and feedback sheet, and I was also present in person to discuss any feedback directly. This process was particularly helpful for correcting ambiguous wording. After further modifications following feedback from mothers on the postnatal ward, the confirmed version of the 1995 survey form was prepared for distribution. It was modified again in 1997 and 1999 in order to capture additional data on emerging issues. For example, the 1997 survey form included questions about selecting and changing a Lead Maternity Carer. The 1999 survey form included a section on fee charging for the provision of maternity care. Survey forms used in each of the three data collection periods are reproduced in Appendices Four to Six.

5.3 Data Collection

In both 1995 and 1997, a mix of survey data and in-depth interviews was used to establish an evaluative picture of local maternity services. Survey forms and invitations to be interviewed were distributed by postnatal ward staff in maternity units throughout the Central region and by independent midwives to women who had given birth to a live baby within a specified four week period each year for the survey, and a specified one week period each year for the interview invitations. Shortly before the survey periods commenced I arranged for the postage of a quantity of survey forms to each of the independent midwives working in the Central region. The mail out was managed by the Central Regional Health Authority using midwife names and addresses from their provider database. While the mail out was in progress, I visited each of the maternity units in the region to meet with maternity unit managers and ward staff, and to drop off survey forms and survey return boxes. Survey respondents, who at all times were responding anonymously, had the option of returning the survey form using the enclosed free post envelope, or by dropping it into the survey return box on the postnatal ward. At the end of each of the survey periods, I returned to each of the maternity units to collect survey return boxes and distribute interview invitation forms. A second posting to independent midwives was also arranged to distribute interview invitation forms through this source. Survey and interview participants for each of these years were drawn from separate time bound samples (four weeks and one week respectively).

In 1995 a total of 502 survey replies were received from a possible sample of 989 women, yielding a 51% response rate. In 1997, the response rate fell to 40% (a total of 332 replies received from the possible sample of 821 women). The response rate was in part dependent on the comprehensive distribution of survey forms by midwives based in Crown Health Enterprises (CHEs) and independent midwives throughout the region. Although the aim was for every woman who gave birth to a live baby in the Central region within the four week survey period to receive a form, it is probable that in practice, distribution fell short of this target. At the time that the 1997 survey was running, one CHE was in the process of relocating and restructuring its maternity services, another was stretched to capacity because it was providing emergency secondary services maternity cover for a neighbouring CHE, and in a further CHE, despite the goodwill and support of management for the research, none of the survey forms which were delivered to the hospital were distributed to women. (The number of live births during the survey period for the latter CHE has been deducted from the regional total given above. Therefore, the sample of 821 women includes six of the seven CHEs in the Central region.) These occurrences are perhaps symptomatic of the well recognised and widespread stresses attendant upon New Zealand's health sector in the 1990s. However, despite the fact that the 1997 response rate was lower, the demographic profiling detailed in Chapter Seven suggests that the survey sample is adequately matched to the population of interest.

The 1995 sample size of 502 delivers a margin of error between 1.9% and 4.4%, with a 95% confidence level. Using the same confidence level, the 1997 sample size of 332 yields a margin of error between 2.3% and 5.3%. The margin varies within these boundaries according to the proportions of responses for any given question.

The sampling frame for the 1999 national postal survey was all women recorded with Health Benefits Limited (HBL) as having given birth to a live baby in February and selected weeks in March and April 1999. Survey forms were posted directly to 5359 women. Twelve percent of the posted survey forms were undelivered due to changes of address. This was largely due to the fact that the address data held by HBL were recorded at the time that women registered with an LMC. There was clearly significant mobility among this group of women during the months of pregnancy. Subtracting the total for 'return to senders' (652) from the original sampling denominator of 5,359 gives a total of 4,707 survey recipients. A total of 2,192 completed surveys were received from the possible total of 4,707 survey recipients, yielding a response rate of 47%. This sample size carries a margin of error of 2%.

The 1995 and 1997 survey data was complemented by semi-structured interviews of about one hour's duration which took place in the homes of an additional 69 women throughout the region. All 1997 interviewees (36) had given birth after April 1997 (i.e. at least nine months after the changes had been implemented). In 1995, 33 interviews were conducted. Although most of the interviewees lived in urban centres or provincial townships, interviewers travelled to rural locations for four of the 1995 interviews and eight of the 1997 interviews. The method for recruiting interviewees was as follows. During a selected week in 1995 and 1997, interview forms were distributed to all women in the Central region who had given birth (excluding stillbirths) during a specified week, inviting them to participate in an interview. Those who indicated by returning the tear off slip by post that they would be happy to consider being interviewed, were followed up by the principal researcher. In order to ensure adequate representation of all major ethnic groups, Maori and Pacific Island interviewers were subcontracted to network for additional interviewees and conduct these interviews. In the findings reported below, the terms "survey respondents" and "interviewees" are used respectively to refer to the two samples of participants. The term "research participants" encompasses both groups.

For reasons of timing and resource constraint the 1999 national survey was not complemented by a national collection of interview data. The findings relied instead on the explanatory and contextualising content of the guided and open ended "further comments" sections of the survey to add a greater depth of meaning to the quantitative data.

Respondents in each of the survey years were given the opportunity to request a summary of the survey results. A second free post envelope and tear off name and address slip was provided to facilitate this while preserving anonymity for the survey responses. A large proportion of respondents took up this option for each of the survey periods. A full copy of the report detailing the comparative analysis for the 1995 and 1997 data collection periods was made available to interview participants.

5.4 Data Analysis and Reporting

The majority of survey questions used a Likert scale to guide responses. Quantitative survey response data were entered into worksheets and analysed using Minitab (Release 10 and Release 12; Minitab Inc, USA). Qualitative data were transcribed, coded and grouped according to thematic content. Analytic files were built up from individual coded data segments. These were established and maintained in an electronic format (Microsoft Word). Emerging issues

were then identified by comparing and contrasting subsets of data both within and between analytic files.

Following the 1995 data collection period, a summary report was prepared for the Central Regional Health Authority. After completion of the 1997 comparative analysis a final report was prepared for the Central Regional Health Authority and individual reports were prepared and distributed to each participating CHE. Following the 1999 national survey, a comprehensive report was prepared for the Health Funding Authority.

Chapter 6: Baseline Data and Analysis (1995)

6.1 Introduction

This chapter presents the findings of the 1995 baseline data collection, which forms one third of the longitudinal sampling frame monitoring trends in consumer perceptions of maternity services. The first sample of data, collected in 1995 was, significantly, a sample of consumer perceptions of maternity services prior to the 1996 implementation of the new maternity services framework. Both the baseline data collected in 1995 and the comparative data collected in 1997 were carried out in the geographical region which was covered by the Central Regional Health Authority. The evaluation data collected in 1999 were drawn from a nationwide sample.

A mix of survey data and in-depth interviews was used to establish the 1995 baseline for consumer perceptions of maternity services. Patterns which emerged from the survey findings were often confirmed and explained by the interview data, and each approach provided unique insights. The *Further Comments* section of the survey, which many women responded to comprehensively, rounded out the data set invaluablely. In the findings reported below, the terms “survey respondents” and “interviewees” are used respectively to refer to the two samples of participants. The term “research participants” encompasses both groups.

The following analysis combines quantitative and qualitative data to examine how women evaluated the care they received during pregnancy, labour and birth, and the postnatal period. The way in which maternity care was arranged, and responsibility assigned between health professionals is also examined. Finally, the section on emerging trends presents a summary of the way participants perceived the changing nature of maternity care over the previous decade.

In general, a very high level of satisfaction with services in the Central region was evident. There were few problems reported with care provided during pregnancy, labour and birth, and women indicated a high degree of confidence in their health professionals. The middle section of the survey contained 30 indicators of satisfaction rated using a Likert evaluation scale. For the most part these indicators were responded to favourably. As many of the results are similar for this part of the survey, an example which is representative of the majority of responses is shown in Figure 6.1 below. (A full set of graphs summarising responses to these questions is reproduced in Appendix 5A.)

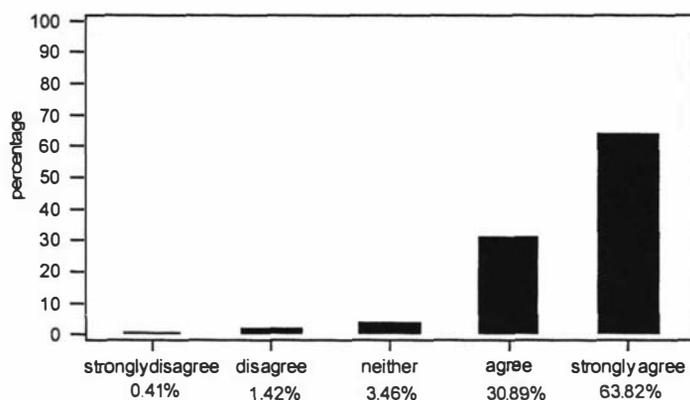


Figure 6.1 Responses to Q15: The care I received during my pregnancy suited my individual needs.

A strong skew indicating a high level of satisfaction, as seen in Figure 6.1, is the defining feature of over half of the evaluative graphs. The predominance of this response underscores the fact that a broad range of services were evaluated positively. At the same time, it forms a useful background for comparison against those aspects of service where evaluation responses highlighted room for improvement. As will be seen below, the highest incidence of reporting scope for improvement occurred in the sections dealing with postnatal care.

6.2 Demographic Profiles

Information was sought on the ethnic group, age range, and educational background of each research participant. The total live births recorded in the Central region for 1995 were distributed by ethnicity as follows: Maori - 16%, Pacific Island - 6%, other (predominantly European groupings) - 78% (data supplied by New Zealand Health Information Service, 1996). The proportions for survey respondents followed a reasonable approximation of this pattern, with 13% of respondents identifying as Maori, 5% as Pacific Island, and 82% with other (predominantly European) categories. With respect to the 33 interviewees, 24% (8) were Maori, 9% (3) were Pacific Island, and the remaining 67% (22) identified with the New Zealand/ European grouping. Four of the latter group lived in rural locations.

Information about the age of research participants is given in Table 6.1 below.

Table 6.1 Age Groupings for Research Participants

Age Group	Survey Respondents		Interviewees	
	Percent	Number	Percent	Number
15 - 20	8%	38	-	-
21 - 25	20%	99	21%	7
26 - 30	37%	185	24%	8
31 - 35	27%	132	24%	8
35 - 40	7%	34	30%	10
over 40	1%	6	-	-

Survey responses were received for all of the age categories listed, with a predictable bulge through the late twenties and early thirties. The interviewee group did not include women from either the youngest or oldest categories, and there was strong representation from the 36-40 age group. Figures from *New Zealand Birth, Abortion and Pregnancy Data* (New Zealand Health Information Services, 1994) suggest the age profile of the survey respondent sample is a good match with the profile of the population it was taken from. Although figures specific to age groupings were not available for 1995, a break down of age groups for each RHA (Regional Health Authority) was available from New Zealand Health Information Service (NZHIS) for 1992. Table 6.2 below is an excerpt from these data.

Table 6.2 Percentages of Births by Age for Central Regional Health Authority in 1992.

Age Group	Percent
19 and under	8%
20 - 24	22%
25 - 29	32%
30 - 34	28%
35 - 39	9%
over 40	1%

Source: *New Zealand Health Information Service, 1994.*

Although the arrangement of categories differs slightly for the NZHIS data and the survey response data, it is clear that in both cases the three most common age groups for giving birth were, in descending order: late twenties, early thirties and early twenties. For both sets of data the rate drops off steeply outside of these groups, with the least common category being over 40.

With respect to educational background, just over half (51%) of survey respondents had completed some form of qualification after leaving school, as was the case for 61% (20) of the 33 interviewees. Clearly there is some bias in the interview group towards older women with post schooling qualifications. This was not wholly unexpected, and is offset to a degree by the more even spread of the survey respondent profiles. When the data set is considered as a whole, the demographic information indicates that data have been drawn from a sample which is broadly representative.

6.3 Care Arrangements

The subject of care arrangements is characterised by plurality. Research participants experienced a diverse range of individual arrangements for receiving maternity care, and arrived at their particular care arrangements through very disparate means. Both the survey and interviews were designed to elicit information about the following: the process prior to establishing a care arrangement; the ways in which women assigned responsibility for care; and their degree of satisfaction with the particular care arrangement they experienced. While the survey provided clear answers to some of the broader considerations that accompany these three central questions, the descriptions offered by interviewees afforded an understanding of the reasons behind the diversity that is associated with this topic.

6.3.1 Recipes for mixing health professionals

For the 33 interviewees in the 1995 study, 14 different combinations of health professionals were described, as listed below. The descriptions relate largely to the arrangements women had in place for their pregnancy and birth. For each case most or all of the postnatal care was undertaken by midwives (either CHE (Crown Health Enterprise) based or independent).

- general practitioner and rostered CHE midwives
- general practitioner and team midwives from the CHE

- obstetrician and rostered CHE midwives
- midwife only
- shared care A - alternating visits with a GP and midwife throughout pregnancy
- shared care B - antenatal care mainly GP, midwife does limited number of antenatal visits towards the end of the pregnancy
- shared care C - antenatal care mainly with midwife, GP does limited number of visits towards the end of the pregnancy
- shared care D - antenatal care mainly with GP, one midwife does limited number of antenatal visits towards the end of the pregnancy and attends labour and birth, while a second midwife does the postnatal visiting
- shared care E - midwife doubles as GP's practice nurse - client sees both at each antenatal visit, some obstetrician consultations as well
- shared care G - antenatal visits shared between GP and obstetrician, rostered CHE midwives and specialist for the birth
- shared care A (midwife and general practitioner, alternate visits) with some obstetrician consultations as well
- general practitioner only for antenatal visits, handing over to hospital team towards the end of the pregnancy
- general practitioner for antenatal visits, rostered CHE midwives and one rostered general practitioner from the general practitioner's practice for the birth
- all care provided by CHE staff (hospital antenatal clinic for pregnancy visits)

The fact that such a broad range came from so small a sample is of itself indicative that there were, at least in theory, very few givens when these women approached the question of care arrangements. However, despite the fact that there were multiple versions operating, it is possible to look at overall patterns. One section of the survey was designed to establish a general picture of the frequency of involvement for different categories of health professionals. Respondents were asked to indicate which health professionals were involved for each stage of care, and reported the following. For pregnancy, 79% of women had a general practitioner involved in their care, 50% had a midwife they identified as their own, and 27% had a specialist involved. For labour and birth, the percentages changed, with 46% receiving care from a general practitioner, 55% from their own midwife, and 35% from a specialist. In the postnatal period, 41% were attended by a general practitioner, with 54% being attended by their own midwife, and 15% by a specialist. (Note that the percentages for each do not sum to 100, as the use of more than one health professional is frequent.) The profile of independent midwives has risen considerably since the return of autonomy following the 1990 Amendment

to the Nurses Act, but it is clear that for the 1995 survey sample, general practitioner care was still the most commonly favoured arrangement, at least for antenatal care. The term “own” midwife includes CHE based options such as “team midwifery” and KYM (Know Your Midwife) schemes, some of which do not have a focus on providing care during pregnancy. This helps to explain the rise in the proportion of women who received care from a midwife they identified as their own for intrapartum and postpartum care. Research participants responded favourably to KYM and team midwifery schemes, as can be seen in the following excerpt from the *Further Comments* section of the survey:

I think the team midwife is a wonderful idea. No individual midwife is under too much pressure. Having a rostered team is brilliant. All the midwives on the team have the necessary information to give great care. The weekly afternoon teas were a wonderful way of meeting the midwife team.

As the attendance of a midwife is required for all labours, and 55% of respondents received care from their own midwife during labour and birth, it follows that 45% of women were attended during labour by midwives working without continuity of care arrangements.

6.3.2 Arranging care

Given that women were experiencing a wide variety of care arrangements, it is worth considering the processes that lead to these arrangements. Any significant discussion about maternity care in New Zealand in the 1990s is likely to include the word “choice,” and some research participants themselves employed the language of choosing when describing their care arrangements - “I opted for” “I chose” “I’d already decided.” However, the degree to which the 1995 environment ensured “choice” for women was highly variable. For some, the particular care arrangements in place for them were very much the result of a conscious choice, while for others the word choice was scarcely applicable. There are three factors operating here: the availability of services; the degree to which women had existing knowledge about possible care arrangements; and the input and influence of the health professionals with whom women made their initial contact.

The availability of services is largely dependent on the woman’s geographical location, since the menu of ‘choices’ available to urban women is much reduced for rural women. To some extent this is a function of the way services are purchased by the RHAs on behalf of the government, but even allowing for this, availability is a much more stable factor than the remaining two, which vary considerably.

An attempt was made to discern the extent to which women had prior knowledge at the time that they established care arrangements, by asking survey respondents to indicate which care options they were aware of at the beginning of their pregnancy. The following list was provided (Survey Question 5):

- *Receiving most of your care from a GP*
- *Receiving most of your care from a midwife*
- *Shared care between your GP and a midwife*
- *Shared care between a midwife and a specialist*
- *Receiving most of your care from a specialist*
- *Receiving care from a hospital team*
- *All of the above*
- *Didn't know I had any choice*

Of all respondents, 34% said they were aware of every care option listed, while 4% indicated that they didn't know they had any choice. The remainder were aware of a subset of the choices listed. The most commonly known about options, in descending order were: most care from a general practitioner, shared care between a general practitioner and a midwife, most care from a midwife, most care from a specialist, shared care between a midwife and a specialist, followed by all care from a hospital team. (As noted above, some limitation regarding knowledge of choices would have been governed by limited availability of services due to rural location). Of all respondents, 61 % reported that they received further information about their choices at some stage during their pregnancy. Health professionals were the most usual source for this information, with family and friends, antenatal classes, and organisations such as Parents Centre, The Home Birth Association and Women's Health Collectives also being cited as sources.

Discussions with interviewees underscored the variability of prior knowledge outlined by the survey data given above. Some interviewees indicated very clearly that they were working from pre-existing knowledge at the time that they made their choice. A minority had planned their care arrangements in advance, as was the case for Stephanie, expecting her first child:

So as soon as we had confirmation [of the pregnancy] I went straight to the midwifery centre. It wasn't through lack of confidence in my GP, it is just that I knew she didn't really specialise in that area and having worked with midwives in the past and knowing, I treat them as specialists. So that is all I ever wanted, a midwife.

By contrast, others like Angela (also having her first), may have had their choices curtailed by limited prior knowledge:

Well actually, I got a fright when she first rang 'cause I didn't know what the heck a midwife was. I'd heard about them, you know they go to your birth, but when she came 'round I said "What am I supposed to see you about?" I wasn't sure about anything.

Many sought to improve their initial stock of knowledge about choices by "asking around" among peers. Choice of an individual health professional was commonly based on word of mouth. For the most part this information gathering process was unstructured and informal, but there were some who took the process much further than most. Helen, for example, likened the pre-choosing phase to checking references for a builder, pointing out that this choice was a far more critical one than choosing the right builder. She describes her preparatory phase in the following way:

We'd already talked to our midwife but the GP suggested I might like to go joint care with her and another specialist. Now, I did a lot of ringing around, and that specialist's name - there was no positive reaction to it, and in the end I had to do a lot of research and found out that yes, she was an interventionist, and that's not what I wanted. It's what I got but it's not what I wanted. And so we had to do our own looking for a specialist and I talked to a lot of people who had specialists and found out who they'd had and whether they'd had good results and said "That's who I want my specialist to be."

The variability of the remaining factor, the input and influence of health professionals, was also highlighted during discussions with interviewees. Some interviewees received care from health professionals who ensured they were aware of the range of options available, as was the case when Sarah visited her general practitioner.

Sarah: When I went to see [my GP] he said basically there's all the different options you can have.

Interviewer: So he laid out the options for you?

Sarah: Yeah. He said you can go with a doctor and a midwife or you can go solo with a midwife or you can go with the hospital team and do it whatever way you wanted. I'd already decided to go with a doctor and midwife 'cause most of the people I know had doctors and midwives and it's worked out quite well.

However, only a minority of interviewees had their care options described comprehensively for them by their care providers. Instead there was a tendency for health professionals to assume that women had chosen before making contact. Some interviewees pointed out that this assumption was correct in their case, while others were disappointed that their options had been limited. Lusi, for example, who had recently immigrated from Samoa, commenced antenatal visits with her general practitioner unaware that he had no intention of attending the birth. This fact was not explained to her until late in the pregnancy when he referred her to the antenatal

clinic at the local hospital. No other options for care were explained to her at this time. She made the following remarks when reflecting on her birth experience:

Next time, I would switch to a GP that does deliveries. I would also choose my own midwife. I didn't like going up to the hospital for antenatal check-ups because each time I had a different doctor and midwife. That was not good. I didn't get to know anyone personally to build up any relationship before I had my baby.

A small number of survey respondents also volunteered opinions on this topic. An example is given below.

I have found that the information given to me by my doctor was not full and after meeting my midwife who is looking after me now I had not realised the full options available to me. My doctor just assumed that I would have the baby in hospital. My midwife explained to me all the other options fully and what could happen if there was any problems. I think doctors need to explain earlier in the pregnancy just what is available regardless of whether it is your first or subsequent pregnancy.

It was common for interviewees to have had a particular midwife or type of midwifery care recommended by their general practitioner or specialist. These recommendations, which were taken up uniformly by interviewees, usually involved CHE based team midwifery care or an independent midwife who would not begin antenatal visiting until late in the pregnancy. A minority however, made recommendations about midwives they would work alongside for alternating visits throughout a pregnancy. For example, when Shelley asked about shared care, her general practitioner gave her a comprehensive list of midwives and singled out four or five he tended to work with. Alternating visits commenced after Shelley chose from the short list of midwives.

Two interviewees spoke about the fact that either their general practitioner or specialist took a proactive role in arranging for a non CHE based midwife to be involved in their care, as was the case for Kathryn:

Interviewer: *So who did you get in touch with first? The midwife, or the specialist?*

Kathryn: *With the specialist - he actually put me on to her - he arranged all that. I didn't arrange it. He said that if I didn't like her that there were lots of other midwives, you know. I didn't have to have her....*

In one case the interviewee was not consulted about whether she would like to have a midwife involved, or whether she would like to participate in the selection of a midwife.

Ruth: My GP must have let somebody know that I was pregnant. [The midwife] phoned me.

Interviewer: At the beginning consultation with your GP did he or she talk to you about the various options that you could have for care?

Ruth: No she didn't. I just got a call from the midwife. I was quite surprised, 'cause I thought that they wouldn't be allowed to give out the information anyway. So I went with her anyway.

It is clear that in general, the first health professional a woman makes contact with, (commonly her general practitioner) exerts a strong influence, whether subtle or overt, over a woman's final choice of care arrangements. What is less clear is to whom we should attribute the verb "choosing", as for many cases, the distinction is blurred between the woman's "choice" and the preference of the first health professional she makes contact with.

6.3.3 Assigning responsibility

As the concept of a lead maternity carer had been foreshadowed at the time the survey was run, data was sought on women's current views about clinical responsibility. When asked if they saw one health professional as having overall responsibility for their maternity care, 64% of survey respondents said "yes." Of these, 54% said they saw their doctor or general practitioner as having overall responsibility, 25% said the responsibility lay with their midwife, and 21% said their specialist or obstetrician had overall responsibility.

The question of assigning responsibility was also explored with interviewees. Some articulated reasons for assigning overall responsibility to a single health professional.

Megan: I think again I'd go for a private obstetrician, because I've had bad complications in late labour.... I'd only be happy with people who could make big decisions on the spot rather than take a wait and see or do it naturally type approach because I think I'm beyond that.

On the other hand, many women experiencing a shared care arrangement did not choose to assign overall responsibility to one care provider, assuming rather a balance of responsibilities between the two health professionals involved in their care. Lorraine, for example, explained her preference for this balance. It is interesting to note though, that key aspects of the new arrangements, which were in an early draft form at the time of Lorraine's pregnancy, had begun to influence her health professionals' assumptions about care arrangements:

Lorraine: I hadn't realised that in going to [my doctor] first, it was assumed that she was my primary care person and my midwife sort of said that to me later on ...

just came up in conversation and it didn't bother me. My midwife actually did the delivery in the end so I sort of left that to them to figure out.

Interviewer: So you didn't feel like you made a conscious decision about choosing...

Lorraine: One over the other - no. I wanted them both because they to me were giving different perspectives, and if something medical had come up I would have gone to [my doctor] and if there was something more midwifery oriented I would have gone to [my midwife].

....

Lorraine: You see, if the shared care option is there, I think it should genuinely be shared care. Both parties should be fully responsible.

Interviewer: And is that how you perceived your arrangement?

Lorraine: Yes. I suppose when I very first ... When I first went into it, the shared care thing when [my first child] was coming I probably thought [my GP] was the big cheese. The doctor was the big cheese and the midwife was her helper, but as time went on I came to see it more as a partnership.

In general, those interviewees who had experienced shared care commended the team work of the health professionals involved and felt confident about the information exchange between their care providers.

Anne, however, had some queries about the way responsibility was apportioned. She received shared care from a general practitioner, and a midwife who doubled as the general practitioner's practice nurse:

I think I was happy with the system here- the midwife and the GP. Although there were times when I didn't quite know who was in charge so to speak.... And I guess I should have known, but it was not quite clearly set out who's your main provider.... Like saying if you've got any problems ring so and so or just a sentence or two early on to set that out.

Sharing care between two health professionals was also described variously as "mucky", "unsettling", "disjointed", and "a bit of a hassle" by a minority of interviewees who found this arrangement less than ideal.

6.3.4 Reflecting on choices

Looking back at their entire episode of care, the majority of both survey respondents and interviewees indicated that they would not make any changes to their care arrangements if they were to have another baby. One of the interviewees summed up the prevailing sentiment with the comment “*I’d like to have the same recipe next time.*” Many positive comments were received about research participants’ main care providers.

The following are some examples from the *Further Comments* section of the survey:

Our midwives were wonderful - sensitive to our needs, and a wealth of birthing information. I would not hesitate to enlist their services for any further pregnancies.

I felt treated very special by all health professionals concerned. Every one of them shared my joy and answered my questions professionally and with respect.

I am more than happy with the care and support I received from my midwife and doctor and the staff at the maternity unit. I have never felt so good about anything before, but I feel like I have achieved a satisfaction in myself and I could not have done it without the support that I received.

The few who did indicate that they would make some changes to their care arrangements said either that they would like to have an independent midwife involved next time, or that they would like to try midwifery only care. One of the survey respondents gives her reasons below:

I started this pregnancy using a GP/midwife shared care approach. Next time I think I will go midwife only care. I respect my GP and he was fine, but the wealth of information and assistance I received was from the midwife. The GP was good if I asked questions - which I did, but I feel it would be hard to get enough information to allow myself a degree of comfort if I was relying on a GP only.

6.4 Pregnancy Care

On the whole, research participants were happy with the amount and type of antenatal care provided for them, and felt that the care they received during pregnancy met their individual needs.

6.4.1 Number of antenatal visits

Traditionally, most women seeking maternity care for an uncomplicated pregnancy in New Zealand have found that their health professional requested visits every month until the 28th week of pregnancy, followed by fortnightly visits until the 36th week, and thereafter weekly visits until birth at around 40 weeks. This schedule of visits, accepted by many health professionals as the norm, equates to about 13 visits. Survey respondents gave the following replies (Table 6.3) when asked how many times they saw a health professional during their pregnancy:

Table 6.3 **Number of Antenatal Visits Attended by Survey Respondents**

Number of visits	Percentage of respondents
0 - 5	4% (19)
6 - 10	19% (95)
11 - 15	42% (204)
16 - 20	21% (102)
20+	14% (68)

As can be seen in Table 6.3, a high proportion of survey respondents (35%) had 16 or more antenatal visits. Some interviewees expressed concerns that postnatal care was under resourced and under emphasised relative to antenatal care, and this is one area that could be investigated further, both with respect to consumer satisfaction and clinical need. Most respondents in the survey sample however, were reluctant to suggest that the number of antenatal visits could be reduced, as can be seen in Figure 5.2 below.

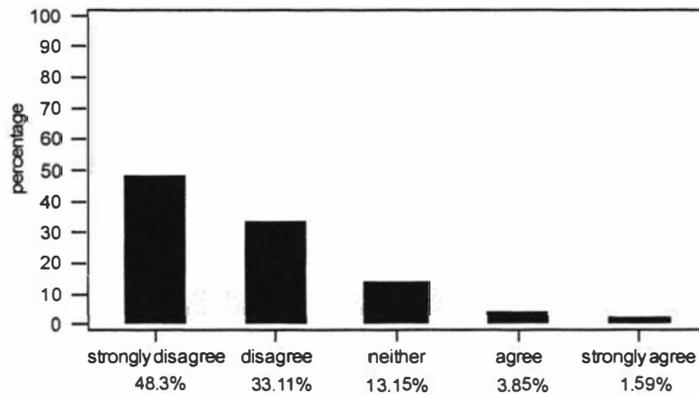


Figure 6.2 Responses to Q17: I think I had more visits with a health professional than I needed.

Nevertheless, a small proportion, (5%) did agree or agree strongly that they had received more visits than they needed, while a further 13% remained noncommittal.

6.4.2 Information needs

In general the antenatal phase was a period of care which was evaluated very positively. The main concern highlighted by both samples of participants was the provision and timing of information. There were requests for more information to be given earlier in the pregnancy. In particular it was emphasised that written resource material on how to care for yourself during pregnancy should be given out at the time that pregnancy is confirmed rather than half way through. For some women however, the problem was not so much the timing of information, as the lack of it. A survey respondent and an interviewee discuss the difficulties they faced in the excerpts given below.

Survey respondent: In my case my GP was very impersonal, never talked to me at all about what was going to happen to my body or my baby. When I asked a question he quite rudely told me his job was to make sure my baby was growing properly and that he/she was healthy and that was that. He never answered any of my questions and made me feel scared and unsure of what was happening to me. After that day I never went back and I got myself a midwife and it was the best decision I could have made for myself and my child.

Interviewer: And were you happy with the care that you got during your pregnancy?... From the specialist?

Kathryn: He was very nice but, being a first mother basically I had to drag information out of him, and I was very embarrassed about some of the questions,

because you know people tell you things and you don't know and of course, some of them weren't correct and you feel a couple of inches under the table, and just some of the questions you know, things should have been gone into a bit more by him - me being a first time mother.... He sort of never really told me anything. I sort of had to drag the information out of him. I just went there and he checked me out and that was basically it. So I never knew what the hell was going on. But don't get me wrong.... He's very nice and that, but you know, information wise - later on towards the end of it he became quite good.... When I first got pregnant it was quite difficult.

Interviewer: *Were there times you would have liked to ask something but didn't ?*

Kathryn: *Yeah probably... with him being a man for a start and also not knowing things, you know whether these people had told me right, and also forgetting to ask, and you know, feeling a bit stupid and probably with my GP it would have been easier....*

Quantitative data was also collected on the topic of how easy it was for survey respondents to ask their health professionals questions during the antenatal period. These results are shown in Figures 6.3 –6.5.

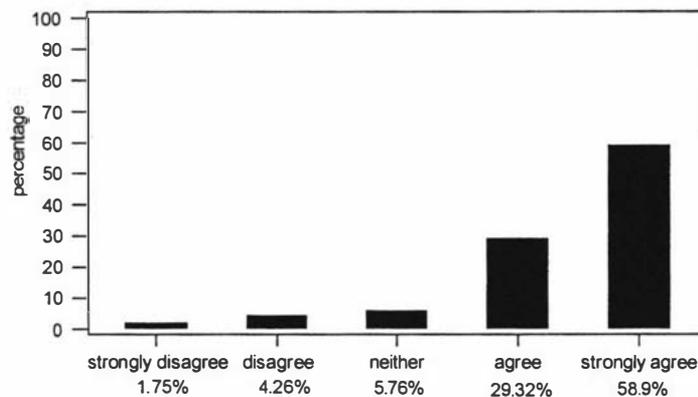


Figure 6.3 Responses to Q19: It was easy to ask my GP questions about my pregnancy. (n=399)

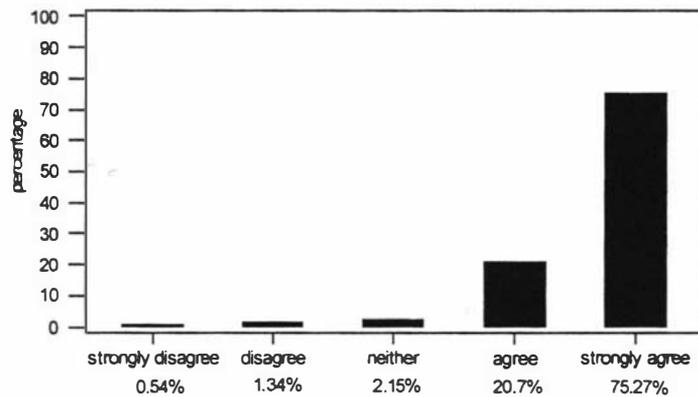


Figure 6.4 Responses to Q20: It was easy to ask my midwife questions about my pregnancy. (n=372)

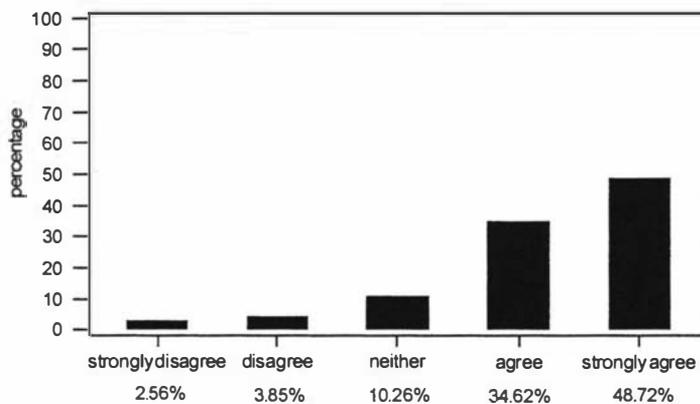


Figure 6.5 Responses to Q21: It was easy to ask my specialist questions about my pregnancy. (n=156)

As can be seen from the graphs above, respondents were most likely to agree strongly that it was easy to ask questions when these were addressed to a midwife (75%), compared to 59% when questions were addressed to a general practitioner, and 49% when a specialist was asked. The combined totals for *agree* and *strongly agree* were high for all health professionals, but the distinction between groups remained - 96% for midwives, 88% for general practitioners and 83% for specialists. A Chi-Square test showed the difference between health professionals to be statistically significant (Chi-Square value = 49, df = 8). Discussions with interviewees highlighted the amount of time allowed for an antenatal consultation as an important

contributing factor to these differences. Some interviewees commented on the fact that their time with the doctor seemed rushed. Most of those who made this comment pointed out that this was not a personal criticism of the doctor, but rather an observation of the way their practice worked. By contrast, several comments were made about the fact that midwives spent more time providing information and support, and discussing concerns.

Christine: I probably didn't ask because my GP is always running late. He was busy. I mean, he didn't brush me off or anything, but I just felt it probably wasn't that important. And it wasn't that important either, but if there had been more time I would have asked.

Lorraine: I felt with my GP visits, they were much more rushed. It was a matter of having a set number of things in my head to ask. And that's, I'm not blaming [my doctor], but that's just the nature of her practice. It's very busy, whereas with a midwife I could take a little more time to, perhaps see what came to mind during the time that she was here. I had an hour long visit with her as opposed to a ten minute visit with the doctor.

6.5 Labour and Birth Care

Following the pattern of evaluation established in the section covering pregnancy care, a high level of satisfaction was reported by research participants for the care they received during labour and birth. Almost all interviewees reported positive birth experiences. Their support and information needs were well provided for, they didn't feel under pressure to agree to procedures, and partners/whanau were made to feel welcome. Survey respondents reported similar sentiments as can be seen in Figures 5.6 – 5.8 below.

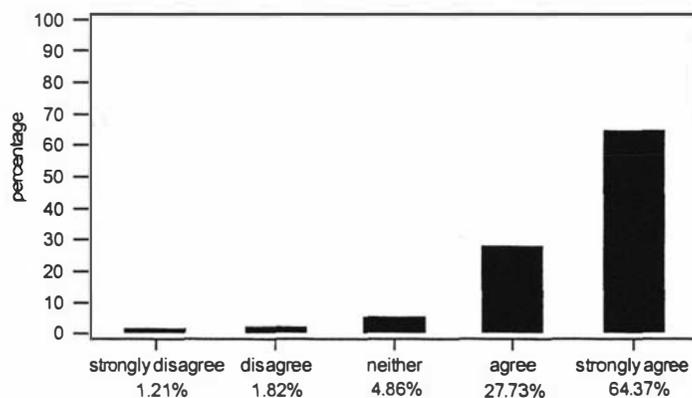


Figure 6.6 Responses to Q26: I got good explanations about what was happening.

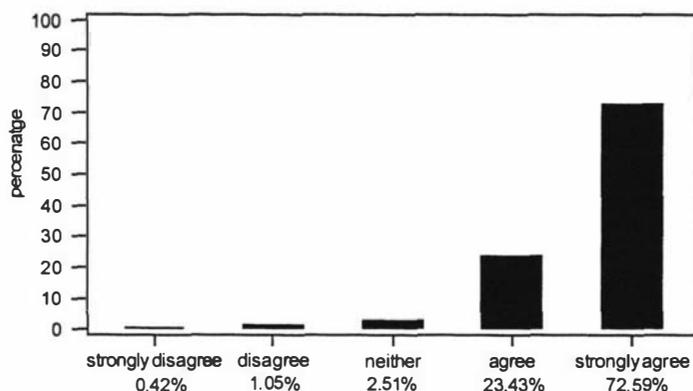


Figure 6.7 Responses to Q27: My support people/whanau were made to feel welcome.

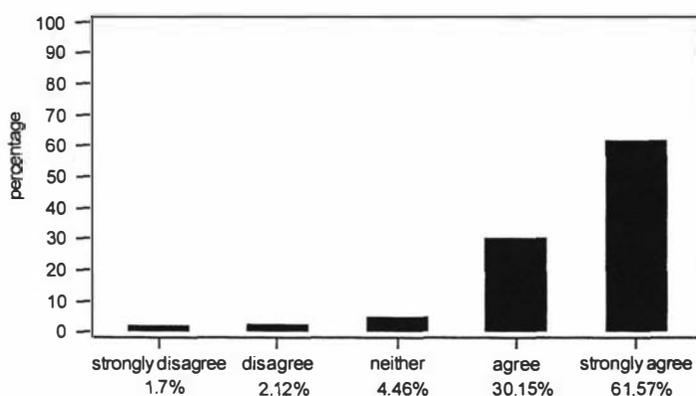


Figure 6.8 Responses to Q32: I had enough privacy during labour.

The quantitative data illustrating satisfaction with labour and birth care was often supported by additional comments volunteered by survey respondents. A sample of these is given below.

From arrival at the hospital to departure all professionals were excellent and made the whole event that much more enjoyable. Father [of the baby] given every courtesy and respect. Made to feel totally welcome.

I felt as though I was in control of the decisions being made and I was supported throughout.

The care and support I received during my labour was great and I will remember it as being beautiful. The midwives here are great and we laughed and chatted and

had cups of tea and enjoyed the long wait for the baby to arrive. The people here at the hospital put me and my partner and family's fears to rest. They taught us to relax and be at ease. It was great. I hope they keep up the good work. I wouldn't change a thing around here.

However, not every survey respondent reflecting on her experience felt that no changes were required to the way services were provided. Although labour and birth care emerged from the evaluation process relatively free of negative issues, there were two problem areas highlighted by research participants. The first of these related to conflict between two or more health professionals. Some interviewees spoke of their concerns about conflict between doctors and midwives in the wider maternity environment, but most commended the team work of health professionals involved in their individual case. Survey respondents, however, reported concerns about conflict based on personal experience. When asked to respond to the statement: 'I felt there was disagreement between two or more of the health professionals involved in my care,' a total of 17% of respondents who had two or more health professionals involved in their care either agreed or strongly agreed with the statement. (See Figure 6.9 below.)

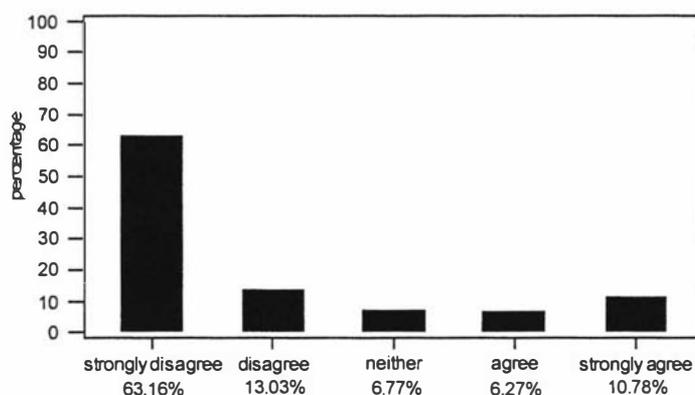


Figure 6.9 Responses to Q31: I felt there was disagreement between two or more of the health professionals involved in my care.

The second area of concern related to the presence of health professionals who were still undergoing some form of training. The critical point here was verbal consent. When research participants had been given a genuine option and had consented to the presence of a trainee they were often prepared to make allowances, as was the case for Christine:

Christine: She wasn't as experienced as the others and she was lovely and really supportive, but she was learning. She actually did the delivery because the GP wasn't there, but he walked in straight after and did the checking. Previous to that they wanted to put an angio in because my first was a Caesar, and the GP said to

put it in as a precaution. So he got the midwife to do that but she couldn't get it in after two attempts, and he said "Oh, well, just leave that. We won't worry about it." But he did ask me at first whether I minded. And she also did the suturing. I had two or three internal sutures and he talked her through doing that too. Which meant that it was a slower process in effect.

Interviewer: So how did you feel about that?

Christine: Well it was uncomfortable. But they'd asked me and that was fine.

However, consent was not sought in every case, and women voiced their objections when this basic courtesy was disregarded. The following comments were made by survey respondents:

Having an intern come into the labour room without my permission, armed with needles etc and telling me I had to have an IV without any explanation was extremely inappropriate.

I don't like having student nurses in the room with me because she didn't even tell me or ask if she could come in. And they were teaching her what to do during labour.

I was made to feel like a guinea pig at the time of the input of the spinal anaesthetic. Didn't get a choice. After one hour the probably learner anaesthetist asked for a professional anaesthetist to administer it. One whole hour of being poked about unnecessarily.

For one of the interviewees, the issue was not so much requesting consent, as a failure to adhere to her preference once stated. Whilst in hospital waiting for an elective Caesarean section, Kathryn was asked if a trainee could attend the birth. She declined, but the trainee turned up in spite of her refusal. A considerable period of time has elapsed since the 1988 Cartwright Inquiry drew attention to the broader issues surrounding informed consent for health care consumers in New Zealand, but it is clear that some health professionals have yet to fully grasp their importance.

6.6 Postnatal Care

By far the largest grouping of concerns fell in the postnatal period. Many women stressed the fact that the time following birth was a time when support, information and advice were vital to them. Once again, Likert scale responses to general questions about service provision were positive (see Figure 6.10 below), and many warm and appreciative comments were made with respect to the health professionals who provided care during this period.

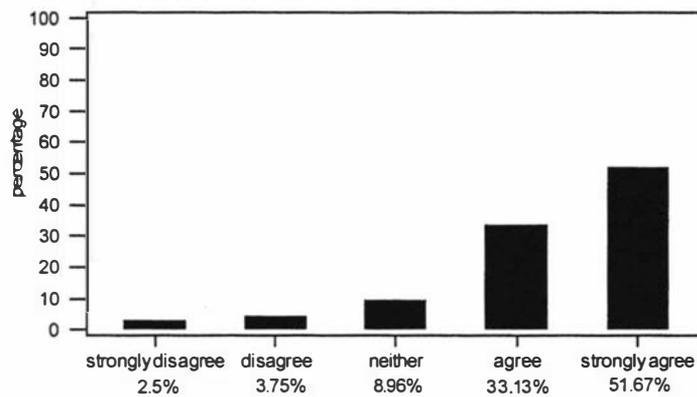


Figure 6.10 Responses to Q42: The care I received after my baby was born suited my individual needs.

However, while most of the quantitative data preserved its positive trend in the postnatal section, the qualitative data produced a stronger counter-current than was the case for previous sections.

6.6.1 Establishing breastfeeding

Many of the concerns raised by participants were linked to establishing breastfeeding. Poor or conflicting advice from postnatal staff in urban hospitals was frequently cited as a concern. Problems arose when advice about how to breastfeed changed with each change of shift, or differed from the advice given by an independent midwife. A few women felt that having a range of advice on offer gave them more choices, but conflicting advice had a negative impact on the majority of those who experienced it, and some left hospital earlier than they had planned in an effort to avoid it. Anne's experience, as described below, was not uncommon.

Interviewer: So who gave you help initially with getting breastfeeding started?

Anne: Well, who didn't? ... I mean a lot of them were very good, but it was whoever was on duty at the hospital and there were sometimes two or three different ones on. Whether they were actual midwives or other hospital staff - seemed to have everyone coming in and giving you advice which often conflicted.

The issue of conflicting advice also produced a significant departure from the positive trend for Likert scale responses. As seen in Figure 6.11 below, a relatively high 20% of respondents either agreed or strongly agreed that they had received conflicting advice about feeding their

newborns. The majority of respondents, however, indicated that they did not receive conflicting advice about breastfeeding.

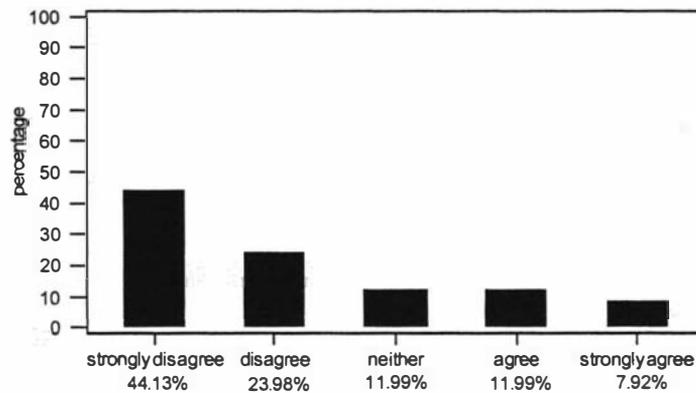


Figure 6.11 Responses to Q44: I got conflicting advice about breastfeeding from different health professionals.

One of the interviewees suggested a solution to the difficulties associated with inconsistent advice about breastfeeding. She recommended an approach which had been used by hospital midwives during her postnatal stay. A breastfeeding plan was discussed with her and documented at the outset, and the notes, which were regularly updated, remained with her for the duration of her time in the postnatal ward. Midwives from subsequent shifts respected the choices which had been documented in the plan. This type of approach may have prevented the problems that another interviewee encountered during her postnatal stay:

Helen: There were a couple of times the midwives in the hospital, in hindsight, really annoyed hell out of me. Because I'm from a farming background I understand about milk flow and if you don't actually ask for it you're not going to get the milk. A couple of times the baby was demanding in hospital and I didn't have anything and they took the baby away because I was really tired and all the rest of it.... And they said "Oh, can we give him some bottled water?" At least they asked. And I said "No." And I think the look on the face of the midwife was - well I really know better than you and you should do what I say... and they said "Well that means we have to bring baby back," and I said "Yes, it does." And I thought that's common sense to me.... and then when I went 'round when I was able to walk and I was bored out of my brains and reading all the stuff 'round the place and here on the staffroom door was a sign that said "The viscous cycle of if you bottlefeed water." I said to [my partner] "It's here. Right beside their door!"

A small number of survey respondents also reported problems with hospital staff offering fluids other than breastmilk to their babies. A bottle or formula was given to the babies of 28% of respondents. In most cases this was in line with the wishes of respondents, but 15% of those

whose babies received water or formula indicated that no-one had asked them first if this would be alright.

Participants stressed the need for staff in postnatal wards to stay with women through an entire feed, watching while they latched the baby on, and staying to offer support and advice while the baby fed. For both interviewees and survey respondents, however, the opposite frequently occurred.

Zoe: I wasn't latching on properly and staff did not have the time to stay.... My sister's experience as well was - her baby was sick - and they just said, "Well, some babies cry a lot" and the staff again did not have the time to sit down with her, stay with her during the feed and answer all her questions and reassure her, until her baby was in special care....

For Jackie, recovering from a Caesarean section, this problem was compounded by her immobility:

One thing that I didn't like was in the middle of the night when I called them to do breastfeeding, they'd just walk off. A few of them would do that, and of course at that stage he sort of wanted it but he wouldn't take much, and of course I couldn't lift him to put him back in, so I just had to sit there and I couldn't understand why they kept walking away. I had to struggle to get up and buzz them again because those cots are quite high, and you know I had trouble putting him in and I couldn't get him out. I think there was once when I did pick him up and I had him and I tried to put him back in and I sort of fell on my side and he was on his side and I couldn't move, 'cause of the wound and that, so I just grabbed the buzzer and I pushed it and nobody came so I pushed it and pushed it and pushed it and of course they came running.... But no, I got looked after really well.

Women were also dismayed that some staff in postnatal wards simply grabbed their breasts and put the baby on without checking first if it would be alright. In addition to the issue of personal privacy, it was felt that this was poor preparation for the mothers to become confident breastfeeders themselves. Comments made by interviewees about this kind of experience were backgrounded by a variety of sentiments. Anne, for example, despite her obvious discomfiture with this approach, rounded out her comments with a note of acceptance.

Anne: They all had their ideas about holding her, but probably it's their own technique I've found hard sometimes. I mean, you know, often they'd grab the baby and they'd grab the breast and they'd force her on... Some of them were quite rough in doing it and they didn't really give you much of a chance, most of them, to find out how to do it yourself. But I mean I've no complaints really about them. That's just the nature of it, I suppose, in a hospital.

Interviewees with previous experiences of this nature approached breastfeeding either with apprehension, or a determination not to let the same situation arise again.

Zoe: I got my nipple yanked - not even asked "Can I touch you?" - my nipple yanked out and twisted around and things like this by this one woman....Just things like that. It was quite invasive [with my first baby]. This time I would not have let that happen and it didn't, which was really good.

For Laila, the predominant sentiment was one of being acutely demoralised:

Laila: 'Cause they treated me really really badly with [my first baby]. They had me sitting there for hours. 'Cause she was in the neonatal unit ... they'd have me go down there and I'd sit in the middle of the unit. They'd put a screen around me and five hundred pillows... I'd have monitors around me going beep, beep, beep. I actually didn't know what to do. They were pulling my breasts in all directions saying "That's no good" and by then she'd be so hungry that she was beside herself. So then they'd give her a bottle and I'd get sent away. And this went on and on...

The following comment, offered by a survey respondent, summarises the failings of the approach described in the excerpts above, as well as suggesting a reason for the prevalence of this approach.

In most cases when asking for advice or help I was inevitably told to sit back whilst they put my baby on and that it would come with time. Not much help considering that I would eventually have to feed by myself - and how much time would it take? Hospital nurses were run off their feet.

Encouraging or requiring passivity is clearly inappropriate, as this leads to a lack of privacy and control, and fails to ensure that the mother is acquiring the necessary skills. However, this approach may well have been favoured by some staff because they were short of time. Talking a mother through the process of breastfeeding, watching while she feeds, and offering reassurance often produces good results, but it requires a reasonable investment of time on the part of the health professional involved. It is clear that in some hospitals, staffing levels did not allow sufficient time for this to happen.

6.6.2 Resourcing for postnatal wards

Concerns about staffing levels were not restricted to the problems women encountered when establishing breastfeeding. The broader issue of staffing in some of the larger urban hospitals drew considerable comment from research participants. It was frequent however for participants to highlight an inadequate level of service provision at the same time as protecting

health professionals from censure. The following selection of comments were volunteered in the *Further Comments* section of the survey:

They do a really good job. They are there if you need help or someone to talk to, but there are not enough of them.

Staff in both hospitals appear to be very stressed, so much so that mothers are afraid to ask for anything for fear of having their heads snapped off.

Please note that this was not the nurses' fault. They were run off their feet. The hospital needs to give them better staffing levels.

Staff too busy 90% of the time.... The after care at both hospitals "through reduced budgets" is absolutely disgusting, and staff indicate the situation is shortly to get worse. Perhaps those collecting performance bonuses need to have babies and use the system they have created, then they should fill out this questionnaire - truthfully.

Low staffing levels also gave rise to additional needs, as described by the following survey respondents:

No information sheets /verbally were given to explain why and how to sanitise toilet seats, where to find more nappies, that it was OK to make yourself a drink of milo or whatever if you missed the tea trolley etc. Little basics to familiarise yourself with for feeling relaxed and knowing what to do in given situations. Often your nurse/midwife was too busy to be concerned with these basic questions, and if you didn't know you go without. Oh for an orientation kit! Delivery staff were very helpful, but ward staff didn't have time.

I enjoyed my experience. The only thing that I would have liked is a ward orientation postnatally, as I tended to sit in my room not knowing where phones, kitchen, TV were, or the ward routine.

Several interviewees who had had postnatal stays in urban hospitals, spoke of the feeling that they were basically on their own. They could get some help or support if they asked for it, but very little was volunteered. Postnatal stays could be lonely, and not particularly restful times.

Anne: I did feel a bit isolated.... I mean it's a nice place there. The rooms are nice. I had a single room. But once my partner had gone for the day, and my midwife came and she'd gone, then I felt really isolated. Here I was sitting in this room and nobody came near me. In fact I went to bed in tears I think 'cause I just felt the anticlimax. Nobody's here saying "How are you going?"

The trend towards discharging women from hospital earlier also drew considerable comment from survey respondents, although no interviewee said that she felt pressured into leaving earlier than she would have liked. The following are a selection of comments from survey respondents:

I feel women, especially first time mothers are being asked to go home too soon after the arrival of their newborns. They should go home once they feel they are ready and capable of coping with the changes in their lives a newborn brings..

Overall health care is excellent. The only comment I would make which is negative is there is pressure put on the mother to leave the maternity ward sooner than she wishes due to the desire to cut costs and relieve pressure on beds.

The pressure was on nearly every mother to leave as soon as possible because of the shortage of beds on the maternity unit.

I do not agree with the earlier discharge, 72 hrs may be enough to get over the initial shock of the birth but relies on mothers having good support at home. Increasingly this is not the case.

There is quite strong indirect pressure to leave the hospital which may affect new mothers already in emotional upheaval, possibly adversely. (Eg comments such as "When are you thinking of going home?" from day one.) I saw one first time very exhausted mother leave within 48 hours after birth who hadn't slept for two nights. Her baby was very unsettled and she was going home expecting lots of visitors to be arriving (but no real help). I understand the financial pressure of the hospital, and that many mothers are ready to leave, but I think the pressure to go is sometimes too strong.

6.6.3 Rural maternity units

Women staying in small maternity units in particular stressed the fact that staff were accommodating, and there was no pressure for them to leave.

The midwives were absolutely brilliant. I felt I had found friends in a number of them. I can't speak highly enough!! There was no pressure to leave, quite the opposite.

This is in line with the generally high level of satisfaction reported by women using small rural maternity facilities. Staff in rural units generally had time to provide good assistance with breastfeeding and mothercraft skills and women left feeling well rested.

The staff are exceptional in that they are most supportive and approachable. In my experience (and also many people I've spoken with) I have come away feeling I'm

leaving home yet welcome to come back or phone home any time. I have also felt positive and confident as a result of the TLC I received. I wish every mother could experience the same positive birth experiences and aftercare that I have received. And I live in hope that this service will be there for my next birth and that I won't be kicked out hours after the delivery, but will be able to benefit from the wonderful aftercare so that I can return home to my other two children refreshed and rested sufficiently.

Not surprisingly, both interviewees and survey respondents expressed strong concerns about the closure of rural maternity facilities, and were very clear about the continuing need for this service.

6.6.4 Learning mothercraft skills

Many participants commented on the need for more time and attention to be given to the teaching of basic mothercraft skills such as bathing a newborn, selecting the right amount of clothing, recognising the kinds of cries that signal pain or hunger, and helping a newborn to bring up wind. One of the interviewees suggested that informal postnatal classes could be arranged, to give new mothers the opportunity to learn from more experienced mothers. In particular, concerns were expressed on behalf of younger mothers, as it was felt that the after care available was not always sufficient to meet the needs of this group of women. It was also suggested that care following birth received inadequate emphasis and funding relative to other aspects of maternity care. A survey respondent and an interviewee voice their concerns on this subject in the excerpts given below.

***Megan:** I've just got really real concerns about the way maternity and post natal care is managed, is going in New Zealand at the moment. Talking to various people, there's a hell of a lot of care put in before people have babies in terms of all the money that's spent on midwife visits and everything like that, and I think that people aren't necessarily better prepared for the realities of actually giving birth, and then I think that afterwards the after care is really lacking, the way Plunket has been chopped back. Not so much in terms of problems with babies but in terms of mothercraft skills and everything like that.*

***Survey respondent:** There is a lot of emphasis on the labour and very little preparation for care of newborns, particularly coping with a crying baby, feeding, tiredness etc.*

6.6.5 Special needs during the postnatal period

Information about how to look after yourself, and getting back to normal following a Caesarean section appeared to be patchy. While some women received good information and follow up, others made clear requests for more information and advice. For elective cases, it was suggested that this information be made available prior to the event.

Two of the interviewees who had serious non maternity related medical needs during their stay in a postnatal ward had their medical needs largely ignored by postnatal staff until their situation escalated to the point where more acute intervention was required. Both interviewees stressed that the escalation in their illness was unnecessary and should have been prevented. In both cases a worsened medical condition had to be coped with in addition to recovering from a Caesarean section, and concerns about a baby who was in the neonatal unit. Pam describes her experience below:

Pam: I get asthma badly, and two days after... 36 hours after delivery I said to one of the midwives on the ward "My asthma's flaring up" and nothing was done and I said "I need some steroids" and nothing was done and by 9 o'clock that night I had to be shifted to another ward so I could be looked after by the medical people... and I complained. I was really sick. I had to go on a drip and have oxygen, and I felt that had I been listened to...you know, it was just a real... they're really experienced with babies and postnatal things but when it comes to other medical conditions it was hopeless...

Interviewer: How long did it take for the asthma to settle down?

Pam: About 24 hours but I was still quite sick after that, it took you know, a couple of weeks and I was really annoyed because I can manage it really well at home, and I do go into hospital sometimes but had I had my own drugs I would have taken them early in the morning and it wouldn't have got to that stage

Communication and access to information for parents who had babies in the neonatal units varied. Where information and access were limited, this led to anxiety and a feeling of isolation for the mothers involved. Positive comments were made about situations where a more inclusive approach was used.

A range of feedback was received concerning paediatric services. One interviewee whose baby was born prematurely, was assured when she left hospital that a paediatric nurse would provide home visits. Home visits did not commence, however, until the baby had twice been re-admitted due to a deterioration in his condition. A happier scenario was reported by a second interviewee whose newborn required paediatric assessment.

Jenny: You know usually you go and see them at their clinics and they say " Right I want you to go to this department and get this done and then come back", and all that. But he didn't. He carried her and he walked around all the departments with us. He was the one that took us all the way around.... He was good. He'd bundle her off, and then he was so good that after we'd been around a few departments having these tests done he said " Mum you look a bit dry. When was the last time you had a drink?" and I said " Oh goodness knows" and he said "Well there's a canteen around there. I'll look after her. You go and get yourself a drink please." And he sent me off. You know he was really good like that whereas a lot of guys wouldn't have even thought of that sort of thing and he just babysat her while I went and had a cuppa. (Laughter) So that was over and above ...I reckon.

6.6.6 Postnatal depression

Data from both sources pointed to the fact that information about the risk of postnatal depression and the support options available is not routinely offered by health professionals. When survey respondents were asked if a health professional gave them good information on this topic, 20% either disagreed or disagreed strongly, while a further 20% remained noncommittal (see Figure 6.12 below). Of all of the data sets linked to a Likert scale, responses to this question exhibited the least amount of skew.

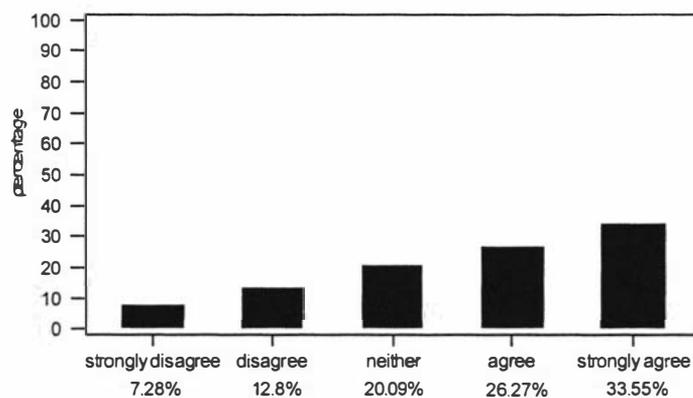


Figure 6.12 Responses to Q41: A health professional gave me good information about the emotional ups and downs that can happen after having baby.

None of the 33 interviewees received information about postnatal depression from the health professionals involved in their care, although some pointed out that their care providers were particularly attentive to their general sense of wellbeing during the days following birth. For others, the level of support and information was scant:

Jackie: The lady doctor kept missing me cause I kept on going down to the neonatal unit... and finally on the Friday she actually came in and caught me, and

she said "How are you?" ... and I cried and she said "Oh it's most common to have the blues on the 5th day." And I just sort of looked at her and I thought, I haven't got the blues lady, I'm so ill. I'm so sick, no wonder I'm bawling. I was quite ill by Friday... She just walked in the door and I can't remember what she said, she only said about a couple of things and I just started bawling, so she just said something else and walked out...

6.6.7 Accessing obstetric records

Many interviewees were not aware that they were entitled to see a copy of their obstetric record, but said that they would like to do so. Some women were aware that they could request a copy but encountered subtle or strong resistance from health professionals and hospital administration staff, as was the case for Zoe.

*Interviewer: And what about your obstetric record, did you get a copy of that?
Zoe: On request, very hard to get out of [the hospital], I felt like I was being interrogated - "Why do I need it?" "Because I want it, and my midwife said that I can get it." I wouldn't have even thought about getting it. I looked at the record and it was really good to have it.*

This question was not explored with survey respondents, due to the timing of the survey distribution and return, which would occur in most cases, prior to the date of discharge from care.

6.7 Emerging Trends

Women who had used maternity services in the Central region in the past were able to make comparisons with previous years. By far the most positive aspect of these comparisons related to a shift towards the partnership model for care provision (Guilliland and Pairman, 1994) which approaches information sharing and decision making with the goal of a balance of power between consumers and health professionals. The following examples from the *Further Comments* section of the survey evidence this shift in attitude.

With my first baby I felt I was treated by the majority of nursing staff in the ward with little or no respect, coarsely. They could be very abrupt and impatient. I felt useless most of the time and felt I was making a nuisance of myself. With my second I was treated with a lot more respect.

Eight years ago with my first born I found the hospital very regimental. It was a bit better with my second three and a half years ago and this time I feel it was quite relaxing. Staff were more happy and friendly and I definitely feel I have a say in matters pertaining to my baby and myself.

As this was my eighth birth over a period of nineteen years, I have experienced change with each of my births. I feel we're getting it right. So good not to be bullied by doctors...

I felt maternity services have greatly improved since I had my first babies (1990 and 1992) Meeting mothers and babies needs (is now) more important than fitting into nursing schedules.

The danger is that when staffing levels are low on postnatal wards some of this progress may be undermined. It is significant that 21% of respondents felt that a health professional was too busy to attend to their needs on at least one occasion. This concern was highlighted in particular by first time mothers, with 29% of mothers having their first baby finding that a health professional was too busy to attend to their needs on at least one occasion, compared with 16% of mothers having a second or subsequent child. The trend towards earlier discharge from hospital may also undermine gains made in other areas, as women see care provision diminishing for a period associated with high need. The answer to this dilemma may lie in part with a changing focus to home visiting postnatally - a service feature which was welcomed by the majority of participants.

Jenny: That midwives system I reckon is excellent. Never had that when ...

Interviewer: Coming to see you in your own home?

Jenny: Yeah... and especially I reckon it's an excellent idea for firsts. You know, I remember when I went home with my first one just feeling so blinking isolated and you know you've got this baby to look after and just overwhelmed by it all. If they had the midwife coming in just once a day that gives you a bit of confidence... and somebody that you can bounce ideas off. Yeah I really like that idea.

6.8 Conclusions

Although in general, women in the Central region evaluated maternity services very highly, it is clear that there were specific areas of concern. The concerns that were most frequently cited, and presented with the greatest degree of urgency, were those related to the period of care following birth. There appeared to be two factors operating here. The first was the issue of resourcing for postnatal care. This affects the amount of care available to women, and also impacts on the quality of care received, particularly in the postnatal wards of larger urban hospitals. Some participants volunteered the opinion that other aspects of maternity care received a disproportionate share of emphasis, leaving the postnatal period under resourced. The second factor was the attitude and approach of health professionals. Reflective comments from participants indicated that health professionals have become more attuned to the childbearing woman's part in the decision making processes related to all aspects of her care.

However, advances of this nature were often lost when staff working on postnatal wards appeared stressed or overworked. Attitude and approach could also be governed to a degree by specific strategies such as the one outlined in the *Establishing Breastfeeding* section above, where the mother's wishes were clearly documented and respected by staff on subsequent shifts.

Chapter 7: Comparative Data and Analysis (1997)

7.1 Introduction

The second data collection period was undertaken one year after the 1996 implementation of the new maternity services framework. Data were collected in 1997 with the dual purpose of assessing the extent to which key aspects of the maternity strategy had been successfully implemented, and comparing consumer satisfaction levels with services provided pre and post implementation. This Chapter discusses the 1997 findings, with selected comparisons to the 1995 data where significant.

Again in general, services were evaluated positively. For the most part Likert indicators were responded to favourably, with over half of the evaluative data sets being defined by a strong skew, indicating a high level of satisfaction. (A full set of graphs is reproduced in Appendix 5B.) This backdrop of approval however, again threw into relief those aspects of care which were highlighted by research participants as topics of concern. A new area of need emerged following implementation regarding increased information requirements, and those sections of the survey and interviews dealing with postnatal care once again attracted the highest incidence of reporting scope for improvement.

7.2 Demographic Profiles

As had been the case in 1995, information was sought on the ethnic group, age range, and educational background of each research participant. Table 7.1 provides data on the ethnic groupings for each set of survey respondents, alongside data provided by the New Zealand Health Information Service (NZHIS) on ethnic groupings for all women who gave birth in 1996 in the Central region. 1996 was the first year that ethnicity data collected by means of self identification, (the method used for this research project) was available from NZHIS. In NZHIS' previous statistical records ethnicity had been defined according to a person's degree of Maori and Pacific Island blood (requiring 50% or more).

Table 7.1 Maternal Ethnicity

	1995 survey	1997 survey	NZHIS data for 1996
Maori	13%	19%	29%
Pacific Island	5%	4%	6%
Other	82%	77%	65%

The percentage of survey respondents is a reasonably close match to the population of interest with respect to Pacific Island women, but falls 10 - 16% below target for Maori women. This was anticipated and corrected for in some measure by the proportions of interviewees for each of the ethnic categories referred to above. In 1997, 31.4% (11) of the interviewees were Maori, 17.1% (6) were Pacific Island, and the remaining 51.4% (19) identified with the New Zealand/European grouping. In 1995, 24% (8) were Maori, 9% (3) were Pacific Island, and the remaining 67% (22) identified with the New Zealand/ European grouping.

Information about the age of research participants is given in Table 7.2 below.

Table 7.2 Age Groupings for Research Participants

Age Group	Survey Respondents				Interviewees	
	1995		1997		1995	1997*
	Percent	Number	Percent	Number	Number	Number
15 - 20	8%	38	8%	24	-	1
21 - 25	20%	99	19%	58	7	6
26 - 30	37%	185	31%	95	8	8
31 - 35	27%	132	30%	99	8	12
35 - 40	7%	34	7%	33	10	3
over 40	1%	6	2%	5	-	-

* Information on age was not collected for six of the 1997 interviewees.

Age distribution was very similar for respondents in 1995 and 1997. Survey responses were received for all age categories listed, with the greatest volume being from women in their late twenties or early thirties. Figures obtained from NZHIS with respect to maternal age for 1996

births in the Central region (see Table 7.3 below) suggest the age profiles for both survey respondent samples are a good match with the profile of the population of interest.

Table 7.3 1996 Birth Data for Central Health

Maternal Age	Percentage
10 - 14	0.02%
15 - 19	7.90%
20 - 24	20.34%
25 -29	30.02%
30 - 34	28.30%
35 - 39	11.48%
40+	1.89%

Although the arrangement of categories differs slightly for the NZHIS data and the survey response data, it is clear that in both cases the three most common age groups for giving birth were, in descending order; late twenties, early thirties and early twenties. For both sets of data the rate drops off steeply outside of these groups.

With respect to educational background, just over half (51%) of the 1995 survey respondents had completed some form of qualification after leaving school. The proportion was very similar (49%) for 1997 respondents.

As the 1997 survey sample had a lower response rate than the 1995 sample, additional information was sought about the specific population from which the 1997 sample was drawn. NZHIS supplied data on the number of Caesarean sections for all births in the Central region within the dates of the 1997 survey run. The section rate for survey respondents (18.83%) was almost identical to the section rate for all women who gave birth within the survey run (18.76%).

Overall, both survey samples provide a reasonable match with the population under consideration. In addition, the 1997 sample shares a very similar demographic profile with the 1995 sample, which is important if comparisons are to be drawn between these two data sets. Non respondents did not form any particular bloc with respect to age, ethnic grouping, or degree of obstetric complication. Therefore the findings are unlikely to be marred by bias stemming from over representation of this kind. Furthermore, the fact that genuinely positive responses were given for the majority of questions indicates that the response group is not dominated by a

disgruntled minority. More than one interviewee suggested that she probably wasn't very interesting to interview because she had had "a straightforward run" and had no complaints. These women were reassured that the aim of the research was simply to piece together an adequate representation of how services were provided for and received by women in the Central region. The demographic detailing above suggests that this goal has been met.

7.3 Care Arrangements

The topic of care arrangements covers the availability of care options, research participants' knowledge about these options, decisions they made based on this knowledge, and the factors that informed and influenced their decisions. The 1997 set of research participants, beginning their pregnancy shortly after the introduction of a new system, had a lot to come up to date with - a point which didn't escape the following survey respondent:

My first contact with a health professional was with my GP who told me that he didn't have a contract and I had to find someone else. Some help/advice needed for newly pregnant people on options!!

Perhaps not surprisingly, the need for more information was one of the most significant areas of concern to emerge from the 1997 set of data.

7.3.1 Information needs

Women's levels of understanding about the new system varied immensely. The key concept of a lead maternity carer was more easily explored in the interview setting than by means of the survey form, as follow up questions and explanations were often needed to ascertain the degree of understanding each woman was in possession of. Data from interview transcripts was supplemented by non directed comments volunteered by survey respondents. Two main points emerged from the data concerning information needs. Firstly, women were working from a number of very different layers of knowledge regarding the new maternity care arrangements, and secondly, they were almost exclusively dependent on their health professionals to equip them with this knowledge.

This second point was articulated succinctly by the following survey respondent:

I feel the main area of concern is in choices and explanations regarding care choice. This is totally dependent on your health care professionals and their level of understanding. Their recommendations are greatly informed by their own particular circumstances and views.

A solution to this problem was suggested by another survey respondent:

It would be good to see the information about choices formally printed and given to all pregnant women, and have somebody impartial they could contact to discuss options.

Analysis of baseline data showed that the degree to which the 1995 environment ensured choice for women was highly variable. The influence of the first health professional a woman made contact with was identified as one of three main factors contributing to this variability. During 1996 and 1997 the extent of this influence magnified as women relied on health professionals to outline the workings of a new system in addition to supplying the normal range of information about aspects of their care which remained unchanged. This influence over a woman's final choice of care arrangements comes through clearly in the excerpts used throughout this section, chosen to illustrate the range of understanding research participants had about the new system and the way it would affect their maternity care.

The interviewees who were most equipped with information about the new arrangements divided into those who were provided with the information by their health professionals, and a smaller subset who were aware of the changes because they were health professionals themselves or because they worked for a health related organisation.

There was evidence that a number of health professionals were taking the time to impart some understanding about the way the lead maternity carer concept had been designed to work. Just over half of the interviewees had gained some comprehension regarding how the LMC concept worked before they reached the second trimester of their pregnancies. The dialogues presented below provide some insight into the degree of confidence women had about their understanding of the ideas underpinning the new system.

Interviewer: Did he explain or she explain, your doctor, about the concept of a lead maternity carer taking responsibility for your care?

Debbie: Yes, yes.

Interviewer: So were you aware that you could have a doctor, or a midwife or an obstetrician as your lead maternity carer?

Debbie: Yes, yes, I was.

Interviewer: And how happy did you feel at that stage with the concept of having an LMC, someone ...

Debbie: It didn't bother me, I thought well ok, that's the way it is, I'm quite happy with that, yeah. That was, I thought it was quite a good idea.

Interviewer: So they talked about the lead maternity carer ...

Helen: Yeah, they would still be able to refer you to specialists and other people as you need them.

Interviewer: So you elected to have a midwife for your lead maternity carer?

Helen: Yes.

Interviewer: And did he talk to you about what kind of options there were for maternity care and talk you through the concept of a lead maternity carer, the LMC?

Sally: He did, yeah, he did. You've got your GP, you've got a GP and midwife or a midwife you know solo by herself, or a specialist and if you have a joint person one of them is your lead caregiver.

Some had grasped the broad direction of the new arrangements but were frustrated by a lack of readily available information on details that were pertinent to their individual situation, as was the case for the following survey respondent:

Only criticism would be the lack of information re: how much do I need to pay? Will the government allocation cover my care? I understand it is to be \$900/per birth. All other services you have a quote /estimate - need to know how much to pay as this may influence your decision on carers. No real written information/pamphlets etc on how the system works and payment/cost you will incur if you choose an option the government allocation doesn't cover. Confusion over referrals - if you are referred to a specialist, are you exempt from further payment? You are unable to choose in this instance? Needs to be a little clearer and communicated more precisely. I find it difficult to understand and I am well educated.

Women also managed to glean some information from the flurry of media reports which accompanied the change to a new system in July 1996. However, the intensely political response to the changes by some health professional groups meant that the media as a source of information tended to be a mixed bag. Media reports did alert some newly pregnant women to the fact that changes had been introduced to the maternity system, and supplied some of the more essential facts relating to the change, but at the same time, created some confusion and anxiety. The following excerpts from Karen's interview transcript illustrate the mix of information and anxiety which was conveyed to her by the media:

I heard a lot of stuff happening in the media so I knew, you know there was changes happening for maternity care, so I rang the Domino Group. But it was interesting because I think in the past I would have just gone to my GP, but because I'd heard so much in the media I didn't bother going to a GP.

....

I don't actually remember when I realised what was going on because I knew there was a change in the structure of payment between the GPs and the midwives and I was trying to figure it out but I think it was still, it wasn't very clear and, yeah, it

was quite an awkward situation, I didn't know quite what to do, but, and then someone just said to me look don't worry about who gets paid , you know, just worry about giving birth....

....

I feel really sad that GPs are pulling out from delivering babies, or being involved with it. There's so much controversy going on.... It would be nice to know exactly what's going on in terms of you know, what's happened between midwives and the GPs. I mean you hear so much in the media and it's all sort of negative and it's coming from the GPs' side.

Clearly a far more direct and consumer focused source of information than what was being served by the media was required. However, getting enough information about how the lead maternity carer concept worked was one thing; personal and obstetric circumstances could be quite another. For Janine, a combination of the need for specialist treatment and her very rural location meant that continuity was difficult to maintain. The concept of a lead maternity carer lost its relevance under these circumstances.

Interviewer: *Were you familiar with the concept of a lead maternity carer, or LMC?*

Lisa: *Yeah they sort of explained that at the start and at various times throughout I had to sign forms - they kept having to you know, do new forms all the time ... like when the GP was doing it here and then when I got down to (the regional hospital) and when I got back here the midwives from (the local hospital) took over once I got home and they said that I had to sign the forms - it didn't really phase me too much, I just signed away.*

Interviewer: *Who was your lead maternity carer then?*

Lisa: *I'm not really sure. I think it was the GP. I don't know who they would've - there was both of them there for quite a while so I don't really know who was the leading one. I signed forms all over so I'm not too sure. I know I signed it back for the midwives since I've been going for my weekly visits since I got home. I had to sign some forms up at the hospital for the midwives 'cause it's gone back to them.*

For the majority of women however, the concept was feasible. Survey data indicated that the message about choosing one health professional to co-ordinate all aspects of your care did seem to be filtering through. As the concept of a lead maternity carer had been foreshadowed at the time the baseline data was collected, survey respondents were asked at that time if they saw one health professional as having overall responsibility for their maternity care. In 1995, 64% of survey respondents replied "yes" to this question. One year after the changes were introduced, the "yes" replies increased to 72%. If more information were to be made available to newly pregnant women about the way the system is designed to work, this percentage would more closely approach the theoretical 100% which is assumed by the vision and service specifications outlined in the July Notice. When asked if they would do anything differently next time, some

interviewees volunteered that they would have an LMC next time, since they had discovered during the interview that they were entitled to nominate one. Just under half of the interviewees received little or no information about the LMC concept and how it related to their individual maternity care arrangements until either; mid to late pregnancy, during labour, or when their interviewer explained it for them six to ten weeks postnatally.

Kay was one of those who found out part way through her pregnancy. When she visited her general practitioner early in the pregnancy, he asked her to sign a form to say that he would be her lead carer, without offering any further explanation. When the midwife came to interview Kay at about 23 weeks, she provided a full explanation about how the LMC concept worked. At this point, feeling that she understood her options clearly for the first time, Kay opted to have the midwife as her lead maternity carer.

A similar experience was outlined by the following survey respondent:

Wasn't advised until quite late in the pregnancy about the LMC and options and by that stage it was assumed that the specialist was the LMC. Midwife advised me of option at eight and a half months when she became involved.

For one interviewee, it was her chance query about the name of one of her health professionals written up above the door of the labour room that lead to her to discover firstly that she had a lead maternity carer and secondly, that her LMC was her general practitioner. Had she known in advance, she would have preferred to have her midwife as the LMC. For others, the interview was the first time the subject had been raised with them. These interviewees responded candidly to the interviewer's explanations or queries with replies such as: "*Oh, right, I've never heard of it,*" or "*No, no. I still don't know.*"

Claire, an interviewee from a rural location, attended visits with three different general practitioners without receiving any information about nominating a lead maternity carer. Midway through the pregnancy the second doctor informed Claire that she wouldn't be attending the birth, and discussed some options with her for ongoing care before transferring her to third doctor who lived closer to the maternity unit. On reflection, Claire wished she'd been with the final doctor from the start. To her it would have been worth travelling the 45 minutes for the sake of continuity. No-one explained the Lead Maternity Carer concept to Claire, despite the fact that each of the second two doctors who provided antenatal care were acting in the capacity of her LMC. She did, however, recall receiving the following instruction: "*Sign the paper so I can get paid by the government.*"

So although it is clear that a number of individual health professionals have taken the time to explain the changes in maternity to women, it is equally clear that in general, health professionals are not a sufficiently reliable source for this information.

Despite the fact that the delivery of information about the LMC concept was patchy, there was another related message which was reaching women more reliably. Many of the health professionals who failed to inform women that they needed to nominate an LMC, did ensure that women knew they could receive care from either a midwife, doctor, or specialist, or in some circumstances, a combination of these. This aspect is not of itself something that has been altered by the July 1996 Notice, although knowledge about these choices is an essential prerequisite to nominating the lead maternity carer. The following excerpt provides a good example of this partial message.

Interviewer: And then when you went to the doctor, did your doctor talk to you about... the idea of a lead maternity carer, the LMC, did your doctor talk about what was happening there?

Anne: LMC?

Interviewer: Yes, see in July 1996, last year, the RHAs brought in a new system for maternity care where people would be required to choose a lead maternity carer or LMC for short and they would have overall responsibility.

Anne: Over them?

Interviewer: For your care, yeah.

Anne: Oh.

Interviewer: No? That wasn't?

Anne: No ...

Interviewer: Yeah, that's what I'm trying to find out, if women have been getting that information, so you didn't?

Anne :No.

Interviewer :Ok, did your doctor talk to you about other health professionals who you could choose to care for you during your pregnancy, like a midwife or an obstetrician?

Anne: Yes, he told me about a midwife and because I had two previous Caesareans I would need care from a specialist.

Data from the survey confirm that information about choosing from a range of health professionals is reaching women. An attempt was made to discern the extent to which women had prior knowledge at the time that they established care arrangements, by asking survey respondents to indicate which care options they were aware of at the beginning of their pregnancy. The following list was provided (Survey Question 5).

- Receiving most of your care from a GP
- Receiving most of your care from a midwife
- Shared care between your GP and a midwife
- Shared care between a midwife and a specialist

- *Receiving most of your care from a specialist*
- *Receiving care from a hospital team*
- *All of the above*
- *Didn't know I had any choice*

Of all 1997 respondents, 39% said they were aware of every care option listed, while 3% indicated that they didn't know they had any choice. In 1995, 34% were aware of all the options and 4% didn't know they had any choice. The remainder were aware of a subset of the choices listed. The most commonly known about options, in 1997, in descending order were: most care from a general practitioner, most care from a midwife, shared care between a general practitioner and a midwife, most care from a specialist, shared care between a midwife and a specialist, followed by all care from a hospital team. In 1995 the order was the same, except for the reversal of 'most care from a midwife' with 'shared care between a GP and a midwife'. Of all 1997 respondents, 69 % reported that they received further information about their choices at some stage during their pregnancy, compared with 61% in 1995. Health professionals were the most usual source for this information, (*"When I found out I was pregnant I went to my doctor and he was the one who gave me the option of midwives that I could contact"*) with family and friends, antenatal classes, and organisations such as Parents Centre, The Home Birth Association and Women's Health Collectives also being cited as sources.

It is likely that survey respondents' initial stock of knowledge about the range of available choices was augmented considerably in the early stages of pregnancy, since most replied affirmatively to the question: *Did you feel that you understood your options for care at the time that you chose your Lead Maternity Carer (LMC)?* This was a new question for the 1997 survey, to which 88% of respondents replied "yes".

7.3.2 Which mix of health professionals?

Some significant changes have occurred since the baseline was established regarding the degree of involvement for the different categories of health professionals. As can be seen in Table 7.4 below, the involvement of specialists has remained quite constant, the 'own midwife' grouping has increased a little, and the involvement of general practitioners has fallen off markedly.

Table 7.4 Responses to Questions 12 – 14: Which health professionals provided care for you?*

	Pregnancy		Labour and Birth		Postnatal	
	1995	1997	1995	1997	1995	1997
Own midwife	50%	64%	55%	63%	55%	58%
General practitioner	79%	53%	46%	27%	42%	10%
Specialist	27%	25%	32%	35%	18%	16%

*Percentages do not sum to 100 as frequently more than one health professional is involved in a woman's care. In addition, some categories are not included in this table.

Although general practitioners were involved in providing antenatal care for 53% of 1997 survey respondents, this involvement halved for care associated with labour and birth, and fell to 10% for the postnatal period. This trend drew comment from the following survey respondent:

Many GPs these days are opting out of birth attendance, but I still feel they put pressure on many women to continue seeing them during their pregnancy, and so deny women the opportunity for better support, and possibly better outcomes during labour/delivery.

The decline of general practitioner involvement between 1995 and 1997 is likely to be due to two main factors. The first of these is the decision by many general practitioners to stop providing maternity care following the introduction of the new arrangements. The second relates to the changing nature of women's preferences, as is illustrated by the survey respondents' comments presented below.

Ten years ago I had to have a midwife and a doctor. I like the option better to have a midwife as the main caregiver as she has a lot of knowledge and is more flexible with home visits and the time spent with her client.

This being my second birth it was good to compare the two. I felt a lot more at ease this time having had the one person (midwife) to deal with throughout the whole pregnancy as the first birth I had the doctor do examinations right till due date then a choice of three midwives to deliver the baby depending in who was on that day. But this time I was able to discuss things long before the birth and feel secure with my midwife. I would choose to have a midwife over a doctor etc in future and I am glad that they are now being recognised for their abilities.

I was originally going to have a GP deliver my baby. But I felt as though the GP thought she was doing me a favour looking after me and offering to deliver my baby. The GP attitude to maternity services was not good at all.

If women were planning to have more than one health professional involved in their care, ensuring good teamwork was a clear priority. This was achieved in a variety of ways, as is illustrated in the excerpts given below.

The one thing I did feel that was really important is that I got a midwife that (my doctor) liked and knew and trusted. Everything I've read, that seems to be one of the key things, so that you don't have these problems. So basically I asked (my doctor) for some names of some midwives... that he works with and rang one up, the one that actually lived the closest and met her for coffee and she was, she became my midwife.

She actually has a particular midwife or two that she likes to work with so she asked me if I'd be happy with her midwife or did I have anyone in mind. Because I didn't know anyone, I just said no I was quite happy to go ahead with her midwife.

I had a shared care arrangement with a GP and midwife. This was the preferred arrangement for the birth of my second child for both my husband and myself. Although the LMC was the midwife, the GP and midwife worked very well together and fully supported me as a team throughout pregnancy and birth - a very positive experience.

Many participants were keen to have the positive care they received from their independent midwife recognised. As is evident in the examples given below, good communication was an especially valued aspect of this care.

Interviewee: It's like anyone who had any questions, I mean she was getting bombarded by both my mothers and all of that, but no it just, you know, quite happy to take the time and do the talking and answer the questions, yeah. And of course whenever she comes everyone comes piling into whatever room she's in to check it out. And the kids still now, when she comes out to check on him, yeah, they come running in with their latest picture from Kohanga or Kura, you know the latest story. So it's really neat. I mean in terms of care, and in terms of being looked after, you just cannot, you can't compare it. It's the most comprehensive you know.

Survey respondent: I found my midwife absolutely fabulous in every possible way - communication was brilliant. I have delivered two sons previous. I was 'under' a GP for the youngest. I would like to say that the GP and specialist did not meet the quality and all round diversity i.e. communication, before during and after labour and general care as what the independent midwife provided. My husband and I are rapt with our decision to have had our 'own midwife'.

However, the following survey respondent was less than enchanted with the services provided by her independent midwife.

Survey respondent: I would not have the same independent midwife again. She seemed too busy, too disinterested etc. By contrast I had an excellent GP and private specialist. A week before my due date I was informed I had a medical condition which meant the safest option for me and more importantly, my baby, was to have a Caesarean. This was duly performed by my private specialist and the hospital team, including hospital midwives. I felt the services and care I received from all of the team was excellent. My own independent midwife did not seem that supportive of the fact that the safest option for me was to have a Caesarean. I found her too blasé about things and not that interested in me. She invariably ignored or 'shut out' my husband (didn't remember his name etc) yet my GP and specialist were very professional and caring and included my husband in discussions etc. I felt my midwife had perhaps too many clients. Her postnatal care (or rather the lack of it) was appalling. Three visits only were made, which I felt was poor.

Clearly opting for one or other type of health professional does not provide any automatic guarantees. Women need to have information about what it is reasonable to expect from their health professionals. Ideally, they need to ascertain whether their health professional's approach to childbirth is compatible with their own expectations and most importantly, they need to receive specific information from their health professionals prior to LMC registration about the amount and type of services their health professional will personally provide or guarantee to arrange.

7.3.3 *The care plan*

Care plan requirements are detailed in the service specifications issued in the July 1996 Notice. All health professionals claiming fees for the specified service 'Registration with Lead Maternity Carer and Care Plan Development' are required to provide the following:

The development and documentation of a Care Plan to be used and updated throughout the pregnancy, birth and following birth. This includes discussion and decision making regarding how care will be provided to meet the woman's /family's needs and their specific service preferences;

- ...
- *an updated Care Plan should be provided to the new Lead Maternity Carer where there is a change in Lead Maternity Carer and the integrity of the original plan should be maintained where possible;*
 - *a copy of the care plan should be held by the woman.*
- (July 1996 Notice, p24)

In 1997, 82% survey respondents reported that they had discussed a care plan with one or more of their health professionals compared with 71% of the 1995 respondents. In addition, 44% of 1997 respondents indicated that the care plan had been written down compared to 23% in 1995 and 16% of 1997 respondents retained a copy themselves, compared with 8% in 1995. Clearly there is room for improvement before the service specifications established in 1996 are being fully met. Discussions with interviewees highlighted the importance of pursuing this goal. In the examples given below, interviewees would have benefited considerably from a clearer understanding of the type of care they would be receiving.

After a two-day stay in hospital, Andrea returned home on a Thursday morning without any clear idea about when she would next see a health professional.

Yeah, and [the midwife] phoned on the Friday and she said - it was all like, I didn't even know what I was supposed to be doing, you know what was happening, nobody told me what to expect and I thought that I would have to phone her, but in the end, no that's right, on the Friday [the doctor] phoned and he said "Have you heard from [the midwife]?" and I said "No, like I don't know what, what's supposed to be happening." And he actually got quite, got quite you know, and he said "If you haven't heard," - he was busy doing something and he said "Well if you haven't heard from her by two o'clock phone me back," and he said "I'll try and come out and see you." Which he never did and then [the midwife] phoned and she said "I'll come out and see you," which she did later that afternoon.

Leanne, whose story is given below, hadn't been told by her midwife that if complications arose and she needed to be handed over to the CHE team, her independent midwife would no longer stay with her. She found out the hard way, amidst the stressful transfer from a smaller hospital to a base hospital.

Leanne: In the meantime my midwife left. She, because she came in in the ambulance and then um...

Interviewer: Did she hand you over to the team then?

Leanne: Yeah.

Interviewer: So she went home. How did you feel about that?

Leanne: I didn't know what to expect. I had a doctor I didn't know, I had midwives I didn't know; the midwives were really good and the doctor was really good, but ... it was a huge shock.

Interviewer: You thought that she was going to be in there?

(pause)

Leanne: (in tears) Sorry.

Interviewer: No, go ahead.

(pause)

Leanne: Yeah, ... and this went on and on and on and um, then they had to use a catheter because I hadn't been to the toilet for ages and, oh they lost the baby's heartbeat and I had to have an internal foetal monitor and this went through till about seven in the morning and the doctor, he's a nice guy, he came in and said well I'm leaving... so he left and the midwife left and a new midwife came on and

she was really lovely as well and, this new doctor came on. And this was when they decided that, the baby still hadn't turned and that I was going to have to have forceps. The doctor never introduced himself to me and the woman who stitched me up, I didn't even know who she was either and ... I had a forceps turning and I didn't even know who this damn doctor was. That's the thing that really got me....

I mean I should have been told, I mean, being the optimist I looked on the bright side, but I should have been told these are the things that can go wrong and these are the scenarios that could happen, and I wasn't given that. I never even thought about it, until it happened

7.4 Pregnancy Care

As had been the case in 1995, satisfaction with antenatal care was generally high. In 1997, 94% of survey respondents either agreed or strongly agreed that the care they received during their pregnancy suited their individual needs (see Figure 7.1 below).

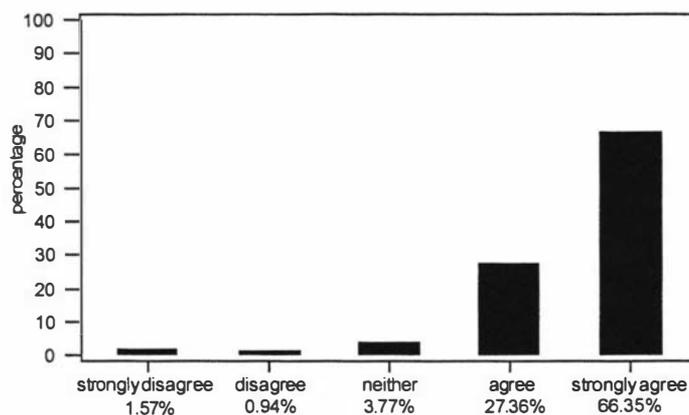


Figure 7.1 1997 Responses to Q15: The care I received during my pregnancy suited my individual needs

7.4.1 Number of antenatal visits

As can be seen in Table 7.5 below, survey respondents in 1995 and 1997 reported almost identically with respect to the number of visits they experienced throughout the course of their antenatal care.

Table 7.5 Number of Antenatal Visits Attended by Survey Respondents

Number of visits	Percentage of respondents	
	1995	1997
0 - 5	3.98%	3.79%
6 - 10	19.47%	19.70%
11 - 15	41.80%	42.05%
16 - 20	20.90%	20.83%
20+	13.93%	13.64%

These data provide some reassurance that the amount of antenatal care being provided for women has not altered as a result of the shift from a fee for service payment arrangement to modular funding. In response to *Q16*: “*I had the right amount of visits with a health professional*” 90% of 1997 respondents agreed with this statement. Respondents who did not agree divided equally into those who felt they had more visits than they needed and those who felt they had less than they needed.

7.4.2 Getting enough information

Quantitative data were collected in both survey periods relating to how easy it was for survey respondents to ask their health professionals questions during the antenatal period. The 1997 results are shown in Figures 7.2 –7.4 below.

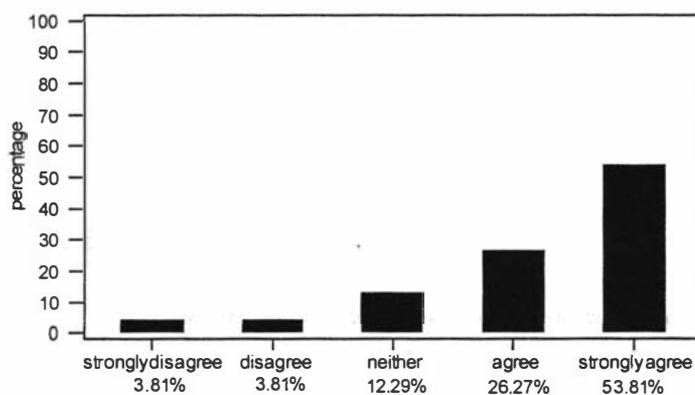


Figure 7.2 1997 Responses to Q19: It was easy to ask my GP questions about my pregnancy. (n = 236)

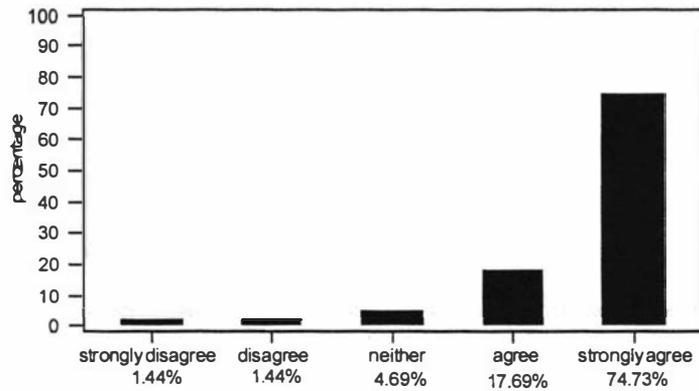


Figure 7.3 1997 Responses to Q20: It was easy to ask my midwife questions about my pregnancy (n=277)

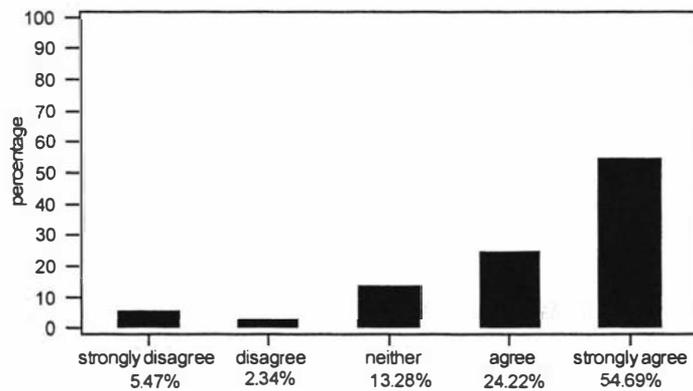


Figure 7.4 1997 Responses to Q21: It was easy to ask my specialist questions about my pregnancy (n = 128)

As can be seen in the figures above, respondents were most likely to agree strongly that it was easy to ask questions when these were addressed to a midwife (75%), compared to 51% when questions were addressed to a general practitioner, and 55% when a specialist was asked. The combined totals for *agree* and *strongly agree* were high for all health professionals, but the distinction between groups remained - 92% for midwives, 80% for general practitioners and 80% for specialists. A Chi - Square test showed the difference between health professionals to be statistically significant (Chi Square value =34.030 df = 8 p = 0.000). For the 1995 data, the

combined totals were as follows: 96% for midwives, 88% for general practitioners and 83% for specialists. The p value for overall responses was similar to the 1997 value.

7.4.3 Referrals to CHE specialists

Women expressed some dissatisfaction with the arrangements for their care following referral to specialists in CHE antenatal clinics. One of the key issues here was lack of continuity, as is evident in the examples given below.

Anita: I'd just like to say about my specialist, I mean I thought it was a bit of a waste of time, because I know I was supposed to go to a specialist because of the Caesar, but I didn't see any point, because I'd visit them, I was told I was going to a certain specialist but they would always have someone else there and then it ended up when I went in to actually have my baby it's not any of them anyway. So I didn't see any point in why I was doing that, but I still did it anyway, but I just don't know why I did it. It happened with my second baby also. Yeah I just thought it was a waste of time- it was never the specialist I was supposed to see, it was always "Oh so and so is here. I'll pass you on to him" and ended up the operation was whoever was on duty anyway, so why was I seeing someone that didn't ..

Interviewer Wasn't going to have any follow through with your care.

Anita: Yeah, and then I ended up getting someone who wasn't even, didn't know anything about my pregnancy, doing my Caesar, so, I don't know what to do about that. Oh, I just thought it was a waste of time. I should have just done it with my doctor.

Interviewer: What happened with those specialist visits? What did they do?

Anita: Same thing the midwives would do. I thought it was a, I mean I'd sit there for about an hour, hour and a half, it's always an hour / hour and a half. It was never less than that. And we'd get in there and they'd just say "How are you?" take my blood pressure, take my temperature, check my stomach, check the baby, and that's it ... say "You're fine," and so I you know I would get really upset about those visits. I did it because I thought if I didn't do it and something went wrong then it is my fault.

Survey respondent: I have very mixed feelings about the antenatal care I received. At 19 weeks a twin pregnancy was identified after a routine ultrasound. My GP then advised me I had to go to a specialist. If we could not afford private care (approx \$1200 for twins) my only option was to go to the public hospital clinic. He also told me I would have to take pot luck as to who I would even see at the hospital. I asked if he could request for me to see a particular specialist. He said he could try. I did get placed under the specialist whose care I requested. I began attending the public clinic at 24 weeks. My visits then were two weekly until I was 32 weeks when they were made weekly. Over the 12 visits I had at the public clinic I was seen by some nine different staff members. The consultant whose care I had been placed under only held his clinic every two weeks, so once I began weekly visits I could only have met with him or his team on alternate weeks. At my 34 week visit I had begun to feel very frustrated with the lack of continuity of care I was receiving and I still hadn't met the consultant personally. After contacting several midwives I wrote to the clinic requesting (demanding) I meet the consultant

whose care I had been placed under at my next antenatal visit. My request was promptly replied to and I met not only with [the consultant] but also the [registrar].

7.5 Labour and Birth Care

Satisfaction with services provided during labour and birth was very high. Most research participants reported that their support and information needs were well provided for, they didn't feel under pressure to agree to procedures, and partners/whanau were made to feel welcome.

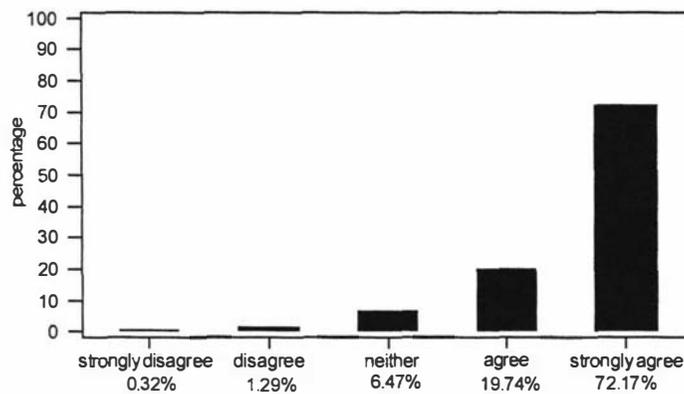


Figure 7.5 1997 Responses to Q36: The care I received during labour and birth suited my individual needs

The qualitative data meshed well with the quantitative data on labour and birth services, affirming the positive message depicted in Figure 7.5 above. Both survey respondents and interviewees commented warmly on the care which had been provided for them.

Survey respondent: I have been very happy with the quality and quantity of health care provided both by my specialist and the [hospital] staff. Everyone has been wonderfully encouraging and supportive in every way. Everyone (bar none) has been friendly, able to answer my many questions and readily available to provide for my many needs.

Interviewee: The staff were just so good, they couldn't do enough for you... you know nothing was too much, they'd run the spa bath for you or run the shower or bring whatever you wanted. It was just great.

However, as had been the case in 1995, one aspect of labour and birth care was highlighted as an area of concern. As can be seen in Figure 7.6 below, 23% of 1997 survey respondents felt there was disagreement between two or more of the health professionals involved in their care.

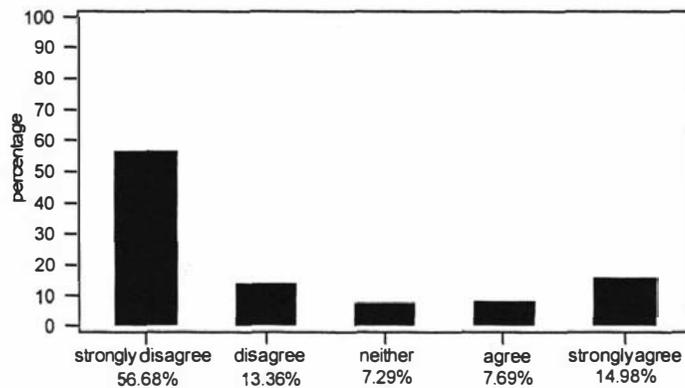


Figure 7.6 1997 Responses to Q31: I felt there was disagreement between two or more of the health professionals involved in my care

This situation has not improved since 1995 and may have worsened slightly (17% of 1995 respondents felt there was disagreement). It would be of interest to return to this question when the concept of a lead maternity carer is more established in New Zealand. However, the bedding down of the concept of a lead carer for primary care may not offer a substantial solution, as a large part of the problem may stem from issues connected to the transfer from primary to secondary care during labour.

7.6 Postnatal Care

As can be seen in Figure 7.7 below, the quantitative data evaluating postnatal care has a reasonable skew towards positive indicators, and some respondents were certainly keen to back up their Likert scale selection with additional comment, such as the following:

This is my third pregnancy.... This birth has had very positive after care. The health professionals have been most willing, caring and helpful to assist before, during and after the birth. I didn't feel I was being 'processed' as I did last time. This time I was 'cared' for.

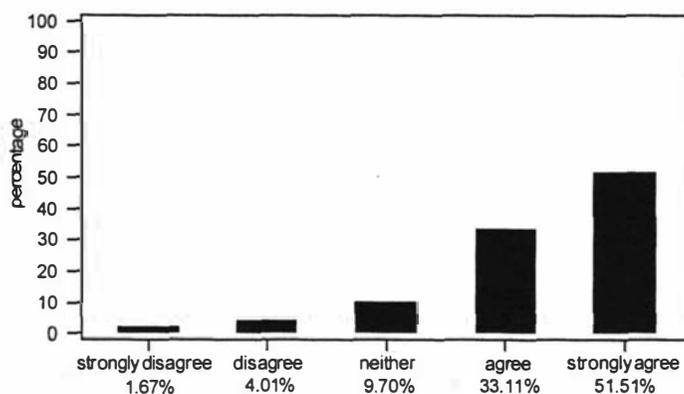


Figure 7.7 1997 Responses to Q42: The care I received after my baby was born suited my individual needs

However, a quick comparison of the shape of Figure 7.7 (postnatal care) and the shape of Figure 7.5 (labour and birth care) suggests that the same group of women who evaluated labour and birth care very highly, were less positive about the services they received after birth. This visual comparison was supported by a Chi Square test (Chi Sq value = 29.817, df = 4, $p = 0.000$), indicating a significant difference in the way these two aspects of care were evaluated.

The most common complaint about care provided postnatally was that there wasn't enough of it. The phrase "You're left to your own devices," which was used by more than one of the research participants, seems to sum up the feeling of those who were less than happy with postnatal care they received.

7.6.1 Pressure to leave hospital

Information about whether or not survey respondents felt any pressure to leave hospital was not directly solicited. However, the comments on this topic volunteered without prompting were plentiful. A selection is presented below.

Only saw nurses when pushed call buttons and got no help with baby (seemed as if because it was my second baby you were left to own devices).... You are certainly made to feel like they want you out of there quickly

I was fortunate to be able to stay in hospital for three nights. Before the birth I was very fearful that I would not have this time to establish breastfeeding and feel if I had to go straight home after the birth, breastfeeding would not have been successful.

The length of stay should be at least five days for new mums and two to three days for second mums. If patients feel the need to go home earlier it shouldn't be because the hospital was too full. Hospital stays should not be a privilege and women should not feel they have to rush home so the hospital staff can cope better. This happens a lot at [my local hospital] - a problem that needs sorting out.

I was readmitted after five days because we were allowed to go home in the third day and I did but then went back because my baby girl had jaundice. Stayed one night then they tried to ask me and another mother to think about going home or staying in [a local hostel] for free but this hostel is 20 minutes away from SCBU [special care baby unit]. This is all because they do not get any funding for re-admitting mothers. We were both breastfeeding and I was down to the SCBU nearly every two to four hours.

I felt scared about being discharged on day four, without having a good handle on breastfeeding. Didn't know who to call at 2 am when it all [went wrong] and latching wasn't happening. I felt it would have been nice to stay a few more days in hospital for first baby - at least until milk had come in and breastfeeding pattern established. Might have avoided bad experience with cracked nipples from poor latching and blocked ducts.

I have been told that from next month the hospital management will kick out mothers after 48 hours. I think that is crazy. Being a first time mother and having a baby with jaundice I have had a lot of trouble feeding. There is no way I was ready to leave after 48 hours.

The subject of pressure to leave hospital was explored directly with interviewees and drew a range of responses. Some were clear that they did not feel pressured at all - "No. In fact, just the opposite." "No, that was my choice, I wanted to go." "No, not this time." "No I didn't have any pressure whatsoever." For others though, a sense of urgency about when they would vacate their postnatal bed was evident.

And I was interested to note the difference, because I had [my first baby] really young and that was in 1989 so I think there was better conditions in the hospitals, like it was OK to stay longer and there was no pressure, no-one asked me until day three whether, how long I was staying with [my first baby], whereas [this time] the first thing they sort of said was you know, "How long do you expect to be in here?"

I think the nurses, in the wards, they could be a bit better, like they gave you the impression they don't really want to be there and I felt like I was being pushed out, like ah, "Do you want to go home? You can go home now if you like," and I didn't really like that. That's why I ended up going home, I didn't want to stay another night "Do you want to go home?" and I think that they're too packed, yeah, they just try to shove you out the door straight away...

After a long and difficult birth, the following interviewee encountered more difficulties in the postnatal period which were exacerbated by pressure to leave.

Sally: They were trying to get me to leave. I was, I got really depressed and because I was so tired and my milk didn't come in for four days and [my baby] just screamed the whole time, she was just so hungry, she just screamed and screamed and screamed and most of the midwives were fine except one who decided that I had to go home and it made no difference whether my milk was in or not and you can just damn well go home. And I'm bawling my eyes out, and yeah, it was just

...

Interviewer: So how long did you stay?

Sally: Three nights.

Interviewer: How did you feel about going home?

Sally: Bloody nervous.

Interviewer: ... you were feeling pressure to leave?

Sally: Oh, big time pressure. She, this one woman even rung up [my midwife] and said "She won't leave."

It is worth noting that the postnatal ward this interviewee was staying in was not full. In general, however, pressure to leave hospital was most frequently evident when the workload on the postnatal ward appeared high for the number of staff available. Under these circumstances, women would often find that contact with staff was minimal.

7.6.2 Amount of contact with health professionals

The question was put to survey respondents "Was there ever a time when a health professional was too busy to attend to your needs?" In 1997 20% of all respondents answered "yes". This concern was highlighted in particular by first time mothers, with 30 % of women having their first baby finding that a health professional was too busy to attend to their needs on at least one occasion, compared with 15% of women having a second or subsequent child. This situation has not altered since 1995, when 'yes' replies accounted for 21% for all respondents, 29% of first time mothers, and 16% of those having a second or subsequent child.

In the following section, the amount of contact women had with a health professional postnatally is examined with respect to the stay in the postnatal ward and the services received after returning home. For the period of time spent in hospital, staff being "too busy" was the most frequent explanation given by survey respondents when contact was minimal.

Hospital was short staffed and it took longer to get things done. Doctors were always busy and it was a long wait all the time. Some staff nurses were nice and apologetic for the wait or delay of things. Medication was forgotten at times. Staff were on the go and patients were forever waiting, or reminding nurses about something they forgot.

From last time I was in hospital two years ago with a baby there has been a marked reduction in services/staff available to patients. On average I had to wait for 20 - 40 minutes for help once I rung the bell.... This wasn't due to staff not wanting to come but due to short staffing.... A lot of women are leaving hospital in one to two days as they are being forced out as a result of overcrowding...

I think the problems are with the system/processes rather than the people involved. Nurses in hospital seemed rushed off their feet, and there were not enough of them to provide a quality service to anyone.

Long wait for anything. Had to ask for everything - no help ever volunteered. Luckily I felt confident enough to do most things myself.

I found the hospital midwives left me to my own devices as I had an independent midwife. But she only called every second day. In between her visits my baby lost all energy, alertness as he wasn't getting his full required milk. It took my husband asking for a paediatrician's advice before the hospital took much notice. By then my baby was badly dehydrated and jaundiced. He was taken off the ward and put in the care of the Newborn Unit....

They say everyone goes home earlier but it's not very attractive to stay! I must add that the nurses really try to do their bit - but a lot feel they don't give any individual time. Makes it hard when you have feeding problems etc.

I feel sorry for health professionals who cannot give the time to individual mothers and babies. It is a gross insult on the part of management who fail to take into account that not only do you have 20 mothers in a full ward, you have 20+ babies!

During my short stay in [hospital] I hardly ever saw staff. Once during each shift did I see anyone.

First 24 hours after birth staff very busy and unhelpful with care of baby - after that it was OK, but I did a lot myself next day. After return to rural hospital I got very good care. I really enjoyed and benefited from my stay in [the smaller] hospital.

Those who, like the survey respondent above, had experienced stays in smaller or rural maternity units, were often keen to get across the message that they had received very comprehensive, warm, and nurturing care during their stay in the unit. One survey respondent said her return to her rural maternity unit after a brief but difficult stay in the city hospital was "like taking medicine for the pain." The impending closure of this rural hospital has since been announced.

As survey form distribution and return in both 1995 and 1997 occurred shortly after birth, survey respondents were not asked how many postnatal home visits they received. The question was, however, taken up directly with interviewees. The range in the number of visits

interviewees reported receiving extended from three to twenty eight, with most reporting a number between five and fourteen. At the higher end of this range, the twenty eight visits provided for one interviewee by her home birth midwife was definitely a single outlier, whereas at the lower end there was a cluster of interviewees who reported receiving three or four visits.

The question of the number of postnatal home visits needs to be considered in conjunction with the length of hospital stay and a range of other factors which influence how a woman perceives the adequacy of the number of visits she receives. Most of those who received three or four visits expressed a preference for more. Some stated clearly that this was an inadequate amount while others were more circumspect. One mother intimated that she was aware there wasn't much money in the health system and that she hoped any visits she missed out on were going to someone more needy than herself. When the interviewer asked one woman who had just had her first child how she felt about the number of home visits she had received (three), she replied that she wouldn't know because she had nothing to compare it to. As was previously argued in the section dealing with the care plan, women need a clear guide about what is reasonable to expect from their health professionals. One interviewee who had a four night stay in hospital, during which time she received good advice and felt well cared for, returned home feeling confident about continuing to care for her baby in her own environment. She elected to have midwifery home visits stop after the third visit as she felt she no longer needed this form of support. She was however, confident that she could contact her midwife if the need arose, and subsequently did request further contact after developing a breast infection.

With respect to those who received five or more home visits, women were more inclined to express satisfaction with the amount of care they received if they were confident that their midwife would be able to provide more care if required. (*"I knew if I had a problem I could ring her and she'd come."* *"I was really happy with the number of times that the midwife came to visit and if I had any queries I mean she was only a phone call away."*) This type of confidence is more usual in continuity of care arrangements where the woman has become familiar with her midwife throughout the course of her maternity care.

In the report on baseline findings, attention was drawn to the trend towards early discharge from hospital. It was posited that the degree to which community based care would provide an adequate counter balance to reduced hospital based services would depend on the adequacy of funding associated with this type of care. In 1997, adequate postnatal services were not reliably provided for all women, as in some cases a minimal hospital stay would be accompanied by minimal contact with health professionals both in hospital and after the return home.

The Auckland based Maternity Services Consumer Council recommends that women receive a minimum of eight to ten midwifery visits postnatally. The 1998 amendment to the Section 51 Notice stipulated the expectation that all women receive five to ten midwifery home visits (or more according to need) with the specific requirement that no woman receive less than five unless she requested this herself.

7.6.3 *Conflicting advice about breastfeeding*

The feedback in 1997 regarding conflicting advice about breastfeeding was similar to that received in 1995. When asked if they received conflicting advice, 19% of the 1997 survey respondents agreed that this was the case, compared with 20% of respondents in 1995.

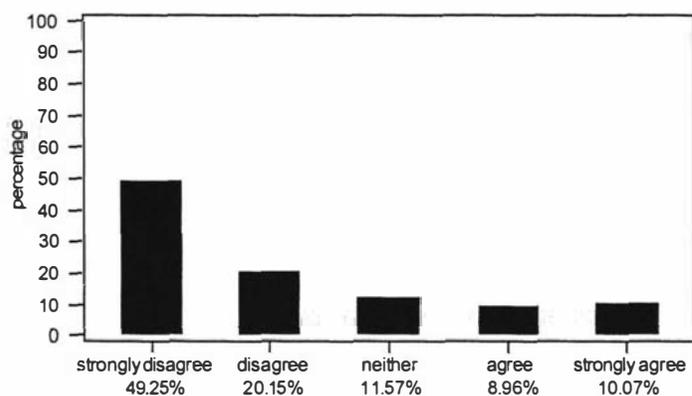


Figure 7.8 1997 Responses to Q44: I got conflicting advice about feeding from different health professionals

Some research participants managed to work around the problem:

The hospital midwives (postnatal care) were generally excellent. I was prepared for the fact that I would receive conflicting advice (which I did) so managed to cope with that OK.

Conflicting advice on breastfeeding was given - it was a matter of finding which advice suited me best and going with it.

But conflicting advice had a negative impact on the majority of those who received it:

Conflicting advice from hospital midwives made life hard at times.

The way breastfeeding is 'taught' in the hospital has as many differing variations as personnel. This definitely is not a helpful practice when your nipples are sore and you're tired and stressed. A consistent policy and approach would really help.

7.6.4 Advice about caring for a newborn and self help strategies

In addition to consistent and supportive advice about feeding their newborns, women need a range of other advice about caring for their babies and themselves in the days immediately following birth. These topics include bathing a baby, helping a baby to bring up wind, choosing the right amount of clothing for a newborn, reducing the risk of cot death, detecting and treating the early signs of a breast infection, assisting the perineum to heal, and steps to take if bleeding suddenly increases substantially. Although some health professionals provided comprehensive coverage of mothercraft skills and self help care, it was evident that this kind of advice was not routinely given. Furthermore, discussions with interviewees as well as a number of the volunteered comments from the survey forms suggest that it is frequently assumed mothers of a second or subsequent child do not need advice.

Ruth: Yeah, I would say one thing, explaining to us even though we've already had children... you still need to be educated, you know just be revised on what's expected. Because I think they just assume that because I've already had two children, but that's like what an 11 year break, they would have assumed that I would have like remembered, but I didn't and I just needed to be reassured and revised on what was I expected to - because I just, yeah I was just left to it. So I found that sort of like a struggle on the first night.

Survey respondent: The nurses expected me to know everything (when I was a first time mum). I got shown nothing.

Survey respondent: Hospital midwives gave good advice on breastfeeding although some of it was conflicting. I received no advice on any other matter regarding myself or the baby from the hospital midwives. This is my third baby and I feel they (hospital midwives) presumed I 'knew it all'.

Deborah: They showed you bathing, but really other than that... I don't know whether it's because I am a nurse that they decided that maybe you know everything, or they think because you're an older person that you've had experience, or what it is, but I just find that most of them in there are really not that helpful at all.

Interviewer: And what about advice about what to look for in the way of breast infections - early symptoms?

Deborah: No, not at all. I ended up with mastitis anyway.

7.6.5 Postnatal depression

Data from both sources in 1995 and 1997 pointed to the fact that information about the risk of postnatal depression and the support options available is not routinely offered by health professionals. When 1997 survey respondents were asked if a health professional gave them good information on this topic, most agreed that this was the case. However, 21% either disagreed or disagreed strongly, while a further 19% remained noncommittal (see Figure 7.10 below).

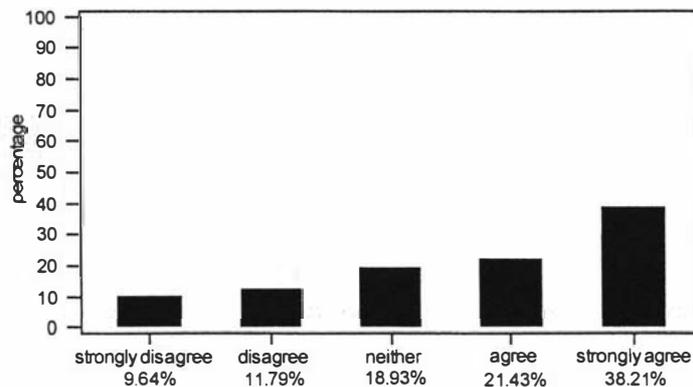


Figure 7.9 1997 Responses to Q41: A health professional gave me good information about the emotional ups and downs that can happen after having a baby

Of all of the data sets linked to a Likert scale, responses to this question exhibited the least amount of skew. Findings in 1995 were very similar, with 20% either disagreeing or disagreeing strongly, and a further 20% remaining noncommittal. Information about the risk of postnatal depression and the support options available is one of the items listed for discussion in the service specifications for the care plan detailed in the July 1996 *Notice*.

7.7 Conclusions

Clearly many of the research participants reflecting on the maternity care they received would agree with the sentiments of the interviewee who volunteered this comment - “*No, nothing could have been improved. Everything was choice.*” However, two key areas of need were identified. The first of these relates to information needs. In 1995 the Joint RHA Maternity Committee released a pamphlet entitled: *Maternity Care - Responding to Women's Needs. Te Manaakitanga I Nga Wahine Hapu - Te Whakahaki Ki Nga Hiahia*. The pamphlet explained

that consultation undertaken by the RHAs had identified the following (among others) as priorities for maternity care:

- Women would like a clearer understanding of their choices for maternity care.
- Women need to know what they can expect from maternity health professionals.

These two key aspects remained priorities requiring attention in 1997. With respect to understanding choices, information about what it means to nominate, and register with a lead maternity carer was the most crucial need. Information about what it is reasonable to expect from health professionals needed to be widely disseminated from an impartial source, in addition to being outlined more reliably by the health professionals themselves.

The second major area for concern was the fact that adequate postnatal care was not being provided for all women. Pressure to make their hospital stay as brief as possible, combined with minimal care both during and after the time in hospital meant that for some, very little support or advice was provided in the days following birth. Research participants expressed urgent concerns about this diminishing care for a time which is associated with high needs.

With respect to the differences between the data collected in 1995 and 1997, it is clear that general practitioner involvement in maternity care has declined. Satisfaction with the amount and type of care provided for women has not altered substantially. Those aspects of care which were evaluated positively in 1995, continued to be rated positively in 1997. At the same time, the 1997 data shows no improvement for those aspects of care which were highlighted in 1995 as areas of concern.

Chapter 8: Review Data and Analysis (1999)

8.1 Introduction

Three years after the implementation of the new maternity services framework, consumer perceptions about maternity care were sampled for a third time, using a nationwide survey. The survey form used for the 1999 national survey was largely based on the original form used in the 1995 and 1997 data collection periods in the Central region, but was updated to capture data on emerging issues in maternity care. This chapter discusses the findings of the 1999 survey

8.2 Description of the Sample

The sampling frame for the 1999 national postal survey was all women recorded with Health Benefits Limited as having given birth in February and selected weeks in March and April 1999. A total of 2,192 completed surveys were received from 4,707 survey recipients, yielding a response rate of 47%. This sample size carries a margin of error of 2%.

Information was sought on the ethnic group, age range, educational background and annual household income of each respondent. In addition, data were gathered on where women gave birth, the degree of obstetric complication involved in the birth and whether the maternity care evaluated in this survey was for a first or subsequent birth.

A total of 2,171 women responded to the question on ethnic identity, with 16% identifying as New Zealand Maori, 5% identifying with Pacific Island groupings and 79% identifying with other, predominantly European groupings, including Chinese (3%) and Indian (1%). Table 8.1 provides data on the ethnic group for respondents alongside data provided by New Zealand Health Information Service (NZHIS) on ethnic groups for all survey recipients with a birth event entry on the National Minimum Data Set (NMDS).

Table 8.1 Comparisons for Ethnic Groups

Ethnic Grouping	Survey Respondents	Survey Recipients
Maori	16%	20%
Pacific Island	5%	11%
Other	79%	69%

Information about the age of survey respondents along with a comparison to age groupings for the data on survey recipients provided by NZHIS is given below. The respondent sample included representation for all age categories, with slightly higher representation for those categories aged 30 and above.

Table 8.2 Comparisons for Age Groups

Age Group	Survey Respondents	Survey Recipients
Under 15	0.18%	0.65%
15-19	4.09%	7.49%
20-24	12.86%	19.76%
25-29	29.34%	30.02%
30-34	33.56%	27.41%
35-39	17.13%	12.96%
40+	2.85%	2.30%

With respect to educational background, 15% of the respondent group (2,145) had left school without any qualifications, 42% had completed qualifications while at school, but had not gone on to complete any tertiary qualifications, and 43% had completed some form of qualification after leaving school. A breakdown of the level of educational attainment for survey respondents is given in Table 8.3 below.

Table 8.3 Highest Level of Qualification Completed by Survey Respondents

Highest level of qualification completed	Percentage of respondents
Left school without any qualifications	15%
School Certificate	19%
Sixth Form Certificate	14%
University Entrance or Bursary	9.6%
A tertiary qualification	43%

Sixteen percent of respondents to the question on annual household income (2029) had an income under \$20,000, with 31% having an income under \$30,000, and 53% having an income under \$40,000. Twenty three percent of respondents had an annual household income in excess of \$60,000.

Table 8.4 Annual Household Income

Annual Household Income	Percentage of Respondents
Under 20,000	16%
\$20,000 - \$29,000	15%
\$30,000 - \$39,000	22%
\$40,000 - \$49,000	16%
\$50,000 - \$59,000	8.6%
Over \$60,000	23%

For 42% of respondents, the maternity care episode they were evaluating related to the birth of their first child. For the remaining 58% it was for the birth of a second or subsequent child.

Table 8.4 below shows the breakdown of birth type. The proportion of survey respondents who gave birth by caesarean section (18%) corresponds closely with the proportion of survey recipients who required a caesarean section (17%). (Data obtained from the National Minimum Data Set as described above).

Table 8.4 Degree of Complication for Birth

Birth Type	Percentage of Respondents
straightforward vaginal	69%
with forceps	7%
with ventouse (vacuum)	6%
by caesarean section	18%

Seventy nine percent of respondents were born in New Zealand, with 21% being born overseas. Eighty one percent of respondents lived in or near a city or major provincial town, with 19% living in a rural location. Hospital births accounted for 95% of survey responses, while home births accounted for 5%.

8.3 Care Arrangements

8.3.1 *Choosing and registering with a lead maternity carer*

The concept of nominating a lead maternity carer who has overall responsibility for providing and arranging care was central to the restructuring of primary maternity care in 1996. Qualitative data gathered in 1997 indicted that women's understanding of this concept was patchy, and that newly pregnant women required more comprehensive information about options and care arrangements. Over a third of the 1999 respondent group were unfamiliar with the concept of a lead maternity carer at the start of their pregnancy and a small number of respondents were still unclear about this central aspect of their care when they were at least half way through their pregnancy.

In reply to the question: *When you first found you were pregnant, did you know that you needed to choose and register with a Lead Maternity Carer (LMC)?* 65% answered "yes" and 35% "no". Those who answered no were then asked if someone explained this to them early in their pregnancy. Eighty six percent of those who hadn't originally known that they needed to choose and register with a lead maternity carer indicated that it had been explained to them in early pregnancy, with the remaining 14% answering no. The number of women in the latter category is 57, which represents 5% of the total survey respondent group. For those who didn't know at the outset but received this information early in pregnancy, the clear majority (76%) received it from a general practitioner, with the second most usual source being family and friends (15%) followed by a midwife (12%).

In answer to the question "*Was it difficult for you to find a suitable lead maternity carer to provide care for you?*", 84% of respondents replied "no". For the 15% of respondents for whom it was difficult to find a suitable lead maternity carer, the following reasons were given (in order of frequency): care from a general practitioner was preferred but not available; preferred or all independent midwives were already booked; care from a private specialist was not available; lack of clarity about options and little information given about how to find and register with an LMC; limited options, particularly for rural women; and shifting residential locations part way through a pregnancy.

The following quotes are a sample of the explanations women gave about the difficulty they had finding a lead maternity carer.

I did not want a midwife but found it impossible to get a GP who would provide care.

Wanted doctor. Rang twelve. Didn't or couldn't take me.

I didn't have any idea where to look for a midwife other than the yellow pages. I didn't know how to choose a suitable midwife, what to ask, what to expect.

They were all too busy at the time to fit me in.

No choices were offered by my doctor.

Everyone thought they were my best choice, e.g. GP, midwife, specialist.

At the time that respondents first registered with a lead maternity carer, about half of them registered with an independent midwife (51%), with the remaining group spread between “own” general practitioner (16%), hospital midwives (13%), private specialists (11%), a general practitioner other than the respondent’s usual one (7%), and hospital teams or specialists (3%).

Most respondents (74%) knew that they could change their lead maternity carers at any stage during their pregnancy and 18% did change LMCs at some point. For those who changed, the most common reason given was that their medical condition required a transfer to specialist care (32%). Other reasons were that the respondent moved to a different location (15%), the respondent wasn’t happy with the care she received from her first LMC (17%) or her first LMC stopped providing care (10%). These were the prompted options, but a large number of respondents (26%) wrote down other reasons for changing. The most frequently given reason from this open category related to the woman’s own preference, usually after sourcing more information about other options or the circumstances of her current registration. The following excerpts illustrate this kind of reason for changing LMCs:

Found you could have someone at your home after working hours. GP did not do deliveries.

Found local GP who would deliver.

Was unaware my own doctor wouldn't attend the birth until a friend told me.

A change in LMC often meant a change to midwifery or hospital specialist based care. The proportion of respondents who had a private specialist as LMC held constant between first registration and the start of labour, but this proportion fell for General Practitioners and increased for all other categories of health professionals. Table 8.5 below shows the

distribution of registrations both at the time of first registering and at the time that respondents went into labour.

Table 8.5 LMC Registrations

Who were you registered with?	First registration	When labour started
Independent midwife	51%	55%
Own GP	16%	8.8%
GP other than my usual one	6.9%	5.5%
Hospital midwife/midwives	12%	14%
Hospital specialist	1.0%	3.0%
Hospital team	1.7%	3.1%
Private specialist	11%	11%

The total group of respondents was broken into subgroups according to the type of lead maternity carer they first registered with, and results were compared for three key questions relating to satisfaction with pregnancy care, labour and birth care and postnatal care. The three questions were:

- *The care I received during my pregnancy suited my individual needs*
- *The care I received during labour and birth suited my individual needs*
- *The care I received after my baby was born suited my individual needs*

The table below shows the combined percentages of 'agree' and 'strongly agree' for responses to each of these questions, broken down by category of health professional that the woman first registered with.

Table 8.6 Satisfaction with Care by Type of Lead Maternity Carer

First registration	Pregnancy	Labour & Birth	Postnatal	Average
IM	92%	89%	77%	86%
GP	90%	84%	73%	82%
Hosp	87%	87%	77%	83%
PS	93%	91%	65%	83%

*IM = independent midwife, GP = general practitioner, Hosp = hospital midwives, hospital specialist or hospital team, PS = private specialist

Although there is some association between type of lead maternity carer and satisfaction with various aspects of care, the wide range of positive and negative comments volunteered by respondents indicates that careful selection of the individual lead maternity carer is as important or more important than a reliance on a particular category of health professional.

8.3.2 Charges for maternity care

Women were asked if they were charged for any of the following services: positive pregnancy test, ultrasound scan(s), care from an obstetrician, care from a general practitioner, care from a midwife. Forty three percent (N=938) of the total respondent group indicated that they were charged for one or more of the listed services or for some other aspect of maternity care. In Table 8.7 below the charges are indicated alongside the percentage of the total respondent group who were charged for each category. The sum is greater than 43%, as some women were charged for more than one category.

Table 8.7 Charges for Selected Aspects of Maternity Care

Service Category	Percentage of Respondents Charged
Positive pregnancy test	7% (N=154)
Ultrasound scan(s)	29% (N=628)
Care from an obstetrician	12% (N=262)
Care from a GP	5% (N=108)
Care from a midwife	0.7% (N=16)
Other	6% (N=133)

Co-payments (a charge made directly to the woman in addition to the fee claimable through Health Benefits) are currently legitimate where care is provided by a private specialist, as is often the case for care from an obstetrician or for ultrasound scanning. However, other health professionals may charge women for maternity care only under limited circumstances. They must have withdrawn completely from the government funding scheme for maternity care, and must inform the woman prior to providing care that he or she will charge and make it clear that the woman can choose to receive free maternity care from other health professionals.

8.3.3 The Care Plan.

As detailed in Chapter Seven, care plan requirements form part of the service specifications detailed in the *Notice Issued Pursuant to Section 51 of the Health and Disability Services Act 1993 Concerning the Provision of Maternity Services (1998)*. All health professionals claiming fees for the specified service: 'Registration with Lead Maternity Carer and Care Plan Development' are required to develop and document a care plan in consultation with the women they are providing LMC services for, and to ensure that women receive their own copy.

In 1999, 150 women provided responses for the section on care plans. When asked "*Did one or more of your health professionals discuss a care plan with you at any stage during your pregnancy?*" 81% of these respondents replied "yes." Fifty percent of all respondents reported that the care plan was written down, and 28% reported that they kept a copy. Comparisons between data collected in 1995 and 1997 in the Central region and the 1999 national sample are given in Table 8.8 below.

Table 8.8 Comparisons of Care Plan Use

	1995 Central	1997 Central	1999 National
Care plan discussed	71%	82%	81%
Care plan written	23%	44%	50%
Woman kept a copy	8%	16%	28%

The proportion of lead maternity carers who discuss care plans improved in 1997 following the release of service specifications in the *1996 Notice*, and appears to be remaining stable. Additionally, there is a trend among the group who do use a care plan towards a more comprehensive alignment with the service specifications relating to keeping a written care plan and ensuring a copy is retained by the woman. Overall, however, there is still considerable room for improvement before service specifications are fully met.

8.4 Pregnancy Care

As had been the case in 1995 and 1997, satisfaction with antenatal care was generally high. For the 1999 national sample, 91% of respondents either agreed or strongly agreed that the care they received during their pregnancy suited their individual needs (see Figure 8.1 below).

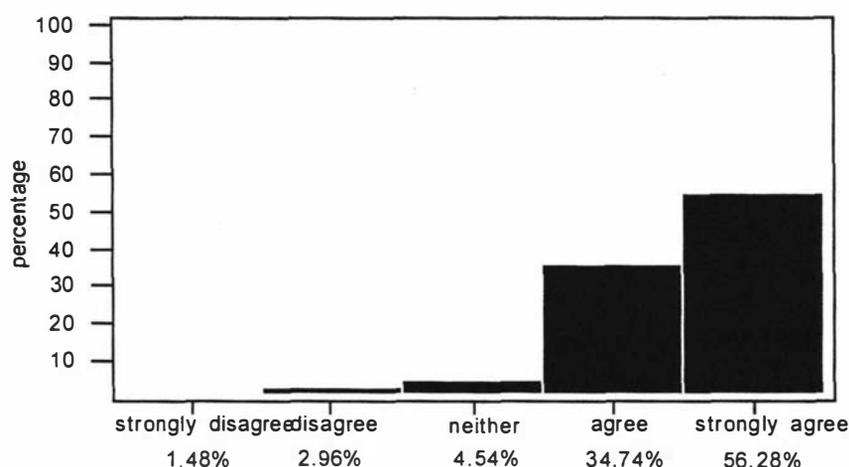


Figure 8.1 The care I received during my pregnancy suited my individual needs.

Information needs were reasonably well met, with 78% of women who received some care from a general practitioner agreeing that it was easy to ask their general practitioner questions about their pregnancy, 93% of women who received some care from a midwife agreeing that it was easy to ask their midwife questions about their pregnancy, and 79% of women who received some care from a specialist agreeing that it was easy to ask their specialist questions about their pregnancy. Eighty percent of the total group of respondents indicated that they got good information about different options for labour and birth.

When asked how many times women saw a health professional during pregnancy, responses did not vary significantly between 1995 and 1997 in the Central region. However, responses for the 1999 national survey did exhibit a different pattern, with respondents indicating that they saw a health professional fewer times during pregnancy than respondents to the earlier Central surveys. An amount between 11 and 15 visits remained the most frequently reported category across all three years.

Table 8.9 Comparison of Number of Antenatal Visits Across Three Years

Number of visits	1995 Central	1997 Central	1999 National
0-5	3.98%	3.79%	6.92%
6-10	19.47%	19.70%	28.04%
11-15	41.80%	42.05%	37.71%
16-20	20.90%	20.83%	17.72%
More than 20	13.93%	13.64%	9.47%

When 1999 respondents were asked if they had the right amount of visits with a health professional, approximately 88% (1898) agreed, with 6% (137) neither agreeing nor disagreeing and 5%(114) disagreeing. Of the 114 women who indicated that they did not have the right amount of visits with a health professional, 54 agreed with the statement: “ I think I needed more visits with a health professional than I got.” This group of women makes up 3.5% of the total respondent group.

8.5 Labour and Birth Care

Satisfaction with services provided during labour and birth for 1999 respondents was very high, and broadly similar to the results for the 1995 and 1997 Central surveys. Most respondents reported that their support and information needs were well provided for, they didn't feel under pressure to agree to procedures and partners/whanau were made to feel welcome. Wishes regarding pain relief were respected for most women, and they had sufficient privacy during labour and birth.

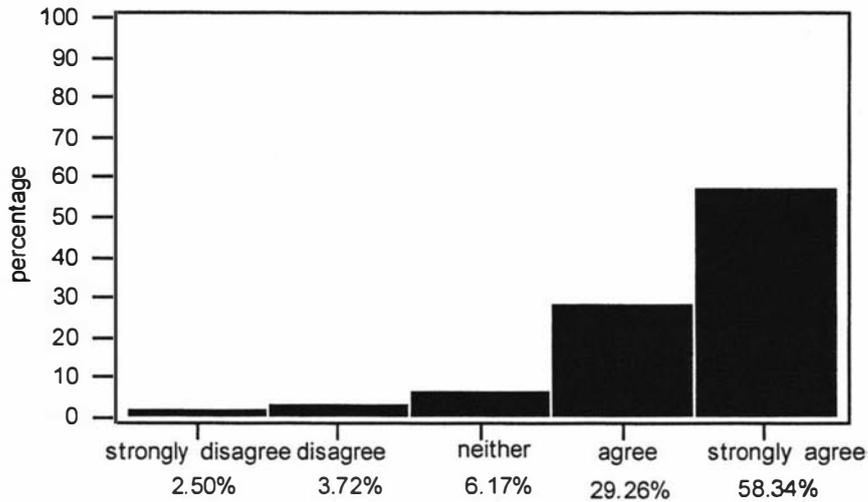


Figure 8.2 The care I received during labour and birth suited my individual needs

However, as had been the case in 1995 and 1997, one aspect of labour and birth care was highlighted for comment. As can be seen in Figure 8.3 below, 21% of 1999 respondents felt there was disagreement between two or more of the health professionals involved in their care. The proportions for 1995 and 1997 were 17% and 23% respectively. However, overall satisfaction with labour and birth care remained high for most of these respondents. Of the 349 respondents in 1999 who agreed or strongly agreed that there was disagreement between two or more of the health professionals involved in their care, 81% also agreed, or strongly agreed that the care they received during labour and birth suited their individual needs.

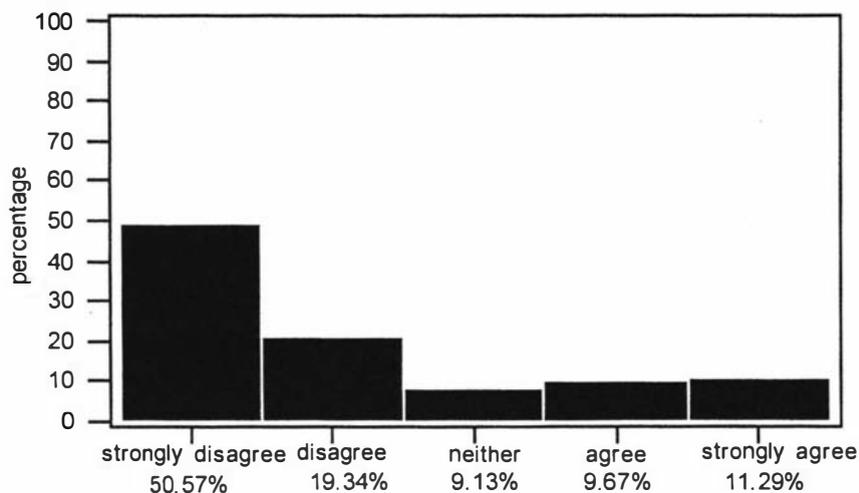


Figure 8.3 I felt there was disagreement between two or more of the health professionals involved in my care.

A new set of data was captured by the 1999 survey relating to the transfer of the LMC role from a primary practitioner to a specialist. Women were asked to answer two to three additional questions only if their lead maternity carer was not a specialist, but a specialist was called in during labour and birth. The number of women fitting this category was 798, and 648 of this group indicated that their care was transferred to the specialist. Eighty four percent of women fitting the first category agreed with both of the following statements: “I feel the specialist was called at the right time” and “There was good communication between my lead maternity carer and the specialist.” Ninety percent of the group of women whose care was transferred to a specialist indicated that the hand over went smoothly. For women making up the 10% who indicated that the hand over did not go smoothly, $n = 62$.

8.6 Postnatal care

The level of satisfaction with postnatal care was not as high as for pregnancy care or labour and birth care, nor were the national set of respondents in 1999 as satisfied with their postnatal care as the respondent groups for the Central region had been in 1995 and 1997. In 1999, 75% of women agreed that the care they received after their baby was born suited their individual needs, compared with 85% for both the 1995 and 1997 surveys.

The main issues affecting satisfaction for women in the postnatal period were the need for adequate and consistent advice and support while establishing breastfeeding, pressure to leave the hospital or maternity unit before women felt ready to go, and the level of support from staff on busy postnatal wards. Thirty four percent of respondents replied “yes” to the question: “During your postnatal stay, was there ever a time when you felt a health professional was too busy to attend to your needs?”, while 16% agreed with the statement “I felt pressured to leave before I was ready.” As can be seen in Figure 8.4 below, 30% of respondents agreed that they got conflicting advice about feeding from different health professionals.

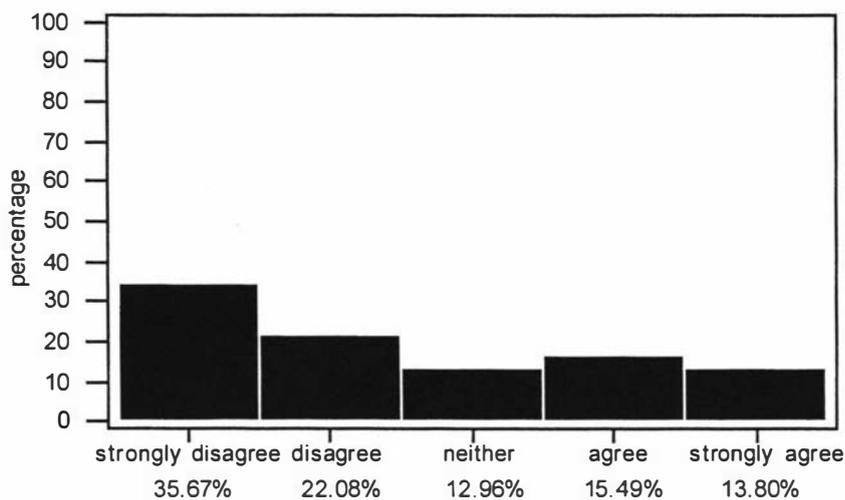


Figure 8.4 I got conflicting advice about feeding from different health professionals

There was also a lack of clarity about the kind of breastfeeding advice and help women could expect from health professionals. Twenty seven percent of respondents disagreed with the statement “My lead maternity carer explained clearly the kind of breastfeeding help and advice that would be available for me” and 25% disagreed with the statement “It was clear to me what sort of breastfeeding help and advice I could expect from hospital staff.”

One of the survey respondents appraised the situation in the following way.

Most of the people I have spoken to that have had children in the last year have been extremely disappointed in the health care at the hospital. A good way to sum it up is the hospital midwives do not think that it is their job to look after you. As far as they are concerned it is your midwife or LMC carer to do this.

The service specifications for primary maternity care outline the following expectations for postnatal midwifery home visits, and the length of time postnatal care should be provided for:

It is expected that women will receive between five and ten midwifery home visits and more if clinically needed. Women may decline further visits at any time. Less than five visits will be provided only in those situations where the woman (and not the Lead Maternity Carer) decides she wishes to receive fewer.

....

The Lead Maternity Carer will be responsible for Ensuring the woman receives integrated and co-ordinated medical, midwifery and other necessary care... for four weeks following birth or for six weeks if clinically appropriate. (1998 Notice, p34 – 35)

However, as the following comment illustrates, fulfilment of these requirements was not always ensured by lead maternity carers.

Following my return home the doctor was great in visiting me, although not as frequently as I would have liked. When I didn't see anyone though for 2 whole weeks (from week 2) I was upset and felt annoyed that I had to chase people up – even now I still haven't had any contact with Plunket and my son is now 9 weeks old.

Of the 1126 women who responded to a question asking them how old their baby was when a midwife visited them at home for the last time, 60% replied that their baby was between four and six weeks old, and a further 6% indicated that their baby was older than six weeks. The remaining 34% of respondents divided into 14% who had a baby aged between three and four weeks at the last visit, and 20% who had a baby aged less than three weeks.

Similarly, the responses to a question asking how many times a midwife visited women in their own home after their baby had been born indicated significant underservicing. Of the 2092 women who responded to this question, 59% indicated that they received between five and ten visits, and a further 7% indicated that they received eleven or more visits. The 34% of women who received fewer than five visits divided into 17% who received four visits, and 17% who received fewer than four visits.

The table below shows the breakdown of number of postnatal home midwifery visits by the category of health professional that the woman first registered with as lead maternity carer.

Table 8.10 Number of Postnatal Home Midwifery Visits by LMC Registration

Number of visits	Less than 5	5-10	More than 10
IM	27.73%	61.70%	10.57%
GP	39.41%	57.60%	2.99%
Hosp	41.61%	52.57%	5.82%
PS	43.43%	54.39%	2.18%

*IM = independent midwife, GP = general practitioner, Hosp = hospital midwives, hospital team or hospital specialist, PS = private specialist.

Two questions were asked about the transition between maternity and Well Child care. When asked if their lead maternity carer talked to them about arrangements for a Well Child provider, 83% of respondents replied “yes” and 17% “no”. In response to the question “*At the time that you had your last maternity visit with your lead maternity carer, did you know who was going to be providing your Well Child programme of visits?*” 85% of respondents replied “yes” and 15% replied ‘no’.

8.7 What should change and what should stay the same?

Survey respondents were invited to record responses to the following two questions:

- What was good about the way maternity care was provided for you? What would you like to see stay the same?
- What was not good about the way maternity care was provided for you? What would you like to see change?

Respondents were more likely to record answers for the first of these two questions than they were to respond to the second. Eighty percent of the total respondent group volunteered positive comments about the way maternity services were provided for them, and 55% recorded comments about what was not good and what they would like to see change.

The group of positive responses was more homogenous than the wide range of comments recorded under the negative category. The most frequently recorded aspects which women wanted to see stay the same related to the professional/friendly/helpful approach of individual health professionals, continuity of care, and accessibility of the woman’s lead maternity carer. Women also expressed appreciation of free maternity care, home visits, availability of care from

their preferred type of LMC (general practitioner, specialist or midwife), and the freedom to make choices and be involved in the decision making about their care. The following is a representative sample of the comments collected under this category.

Don't take away the ability to have an independent midwife. I like the fact that I had one person only handling my care especially during labour/birth. Excellent postnatal care and being able to contact that person at any time of day or night with problems.

I think that it's excellent that we are provided with free care and I hope that it doesn't change. I know a lot more now than before. When my GP told me to find a midwife I didn't because I thought I would have to pay for one.

She visited me at home as well as me visiting her at the rooms. Flexible times. Always contactable. Thirty minute visits – plenty of time to ask questions.

I felt happy to ask about anything with my LMC and if I felt at all unhappy before a visit it was easy to change dates and be checked out. Ease of access to LMCs is good and I hope it stays that way.

Able to call the midwife at any time and if for some reason my midwife was unable there was another midwife to contact in her absence.

The GP and specialist worked very well together and the specialist and hospital midwives worked very well together. There were no conflicting ideas.

My specialist was awesome and I felt very at ease asking questions etc.

My specialist was superb. She was thorough, professional and yet caring and consistent with my needs and personality. Hospital midwives were excellent carers both pre labour and postnatally.

I liked the fact that I called the shots and wasn't bossed around and told what to do during labour.

Choosing my LMC and having the option to change if I wished to. I would like to see that stay the same. I'm keen on women being in charge of the way they birth.

I felt respected and safe. I felt okay to ask questions and express my needs. It was a very empowering experience.

Personal care of my own GP and his practice. I was given all the help and respect of my GP and staff. GPs staying as lead maternity carers.

My GP gave me good maternity care and I would still like to see GPs involved in childbirth and maternity care.

I feel the maternity care in NZ is excellent and I could chose my LMC, which is important, as you need to feel you can talk to that person about anything. I was provided this.

The maternity care I received was a stress free event. My lead maternity carer provided me with helpful advice and a caring attitude. Change nothing.

I have had three children and I have by far enjoyed my last pregnancy etc the most. It was the first time I have had an independent midwife and I wouldn't have had it any other way. I was able to contact her if I had any worries. I felt cared for and was able to discuss with her the choices I wanted and she respected them. By the time my labour started we both knew what was going to happen and I was more relaxed knowing she was going to be there and not some stranger I had never met. I love this new system of choosing an LMC!

The far more disparate group of issues collected in response to the questions: "What was not good about the way maternity care was provided for you? What would you like to see change?" included the following:

- issues about the postnatal hospital stay such as conflicting advice about breastfeeding, pressure to leave the facility, staff being too busy/stretched to provide sufficient care, uncaring attitude of staff, lack of cleanliness in showers and toilets
- conflict/competition between health professionals
- lack of general practitioner care
- lack of shared care
- the cost of private specialists
- paying for doctors' visits
- midwives with excessive caseloads
- inadequate level of care from individual general practitioners
- inadequate level of care from individual midwives
- lack of continuity, especially for hospital specialist care
- inappropriate nappy 'bribes' for leaving hospital early
- lack of information about Maori midwives
- not being able to see the general practitioner without first consulting the midwife
- confusion over care entitlements
- limited information offered about care options
- having to pay for cell phone calls (to contact a midwife)
- insufficient mothercraft skills taught in hospital

8.8 Conclusions

Although the majority of women expressed a high degree of satisfaction with their maternity care, several aspects of care were highlighted as areas of concern.

For women at the outset of their pregnancy the need remains high for independent and comprehensive information about how to arrange care, available options, and the type and amount of care that can reasonably be expected.

There is a need to address the failure of many health professionals to fulfill service specifications and to meet their obligations as lead maternity carers. The key areas highlighted in this study were the appropriate use of care plans, the number of postnatal midwifery home visits, and the length of time postnatal care is provided for.

Finally, there is a need to address the fact that for many women the postnatal facility stay is a less than ideal experience, due to inadequate or conflicting advice about breastfeeding, staff being too busy to attend to the needs of individuals, a lack of sensitivity on the part of some staff or pressure to leave the facility before women feel ready to go.

Overall, however, respondents commented positively on the maternity care that was provided for them, with many volunteering warm and appreciative comments about the individual health professionals involved in their care and several expressing satisfaction with key aspects of the lead maternity carer system, such as continuity of care and the accessibility of their care provider.

Chapter 9 – Retrospective Consultation

In February 1999 the then Minister of Health, Bill English asked the National Health Committee to conduct a review of maternity services because of perceived concerns that had been brought to his attention about the quality and safety of maternity care. Specific concerns related to whether women had access to an appropriate level of care and choice of provider and the reduction in the number of general practitioners offering maternity care. The terms of reference for the review were as follows:

1. To assess the quality of the public maternity service currently being provided and the scope for any improvements in the quality of the service.
2. To assess whether women are satisfied with the public maternity service available to them, including the choice available and whether they are able to make informed choices.
3. To identify any barriers to women accessing maternity care of the type and quality that they need.
4. To identify ways to address issues identified in the review, within current funding levels, to achieve better utilisation of available resources.

The project plan adopted by the National Health Committee centred around three parallel processes: consumer consultation; consultation with providers and other stakeholder groups; and gathering secondary data. The resulting report, *Review of Maternity Services in New Zealand* was released in September 1999 (National Health Committee, 1999). This chapter is concerned with the processes and outcomes relating to consultation with consumers.

Parallel to the consultation process, two methods of sampling were employed by the National Health Committee: a convenience sampling approach and a sample from a defined population. The questionnaires used in each of these approaches were based on the survey instrument which had been developed for the 1995, 1997 and 1999 data collection periods reported in this thesis. A questionnaire seeking the views of women who had given birth since July 1996 was distributed through two magazines – *The NZ Woman's Weekly* (23 March 1999 edition) and *Little Treasures* (April /May 1999 edition). The questionnaire was also distributed through maternity providers, primary care groups, consumer and community organisations. The number of responses received using this format totalled 11,511. A telephone survey, based on similar questions, was undertaken by UMR Insight in June 1999. UMR Insight used a stratified random sample of 1000 recent mothers. There was clearly a degree of duplication in the sampling of

consumer perceptions in 1999. This was driven by the political response to continued vocal opposition, particularly from the medical profession, to the new maternity framework.

Twelve hui were held with Maori mothers identified through the regional offices of Te Puni Kokiri (TPK), and three fono were held with Pacific women in Auckland, Christchurch and Wellington. Meetings were held with rural women living in the Wanganui and Balclutha districts to hear the issues for rural women. Young teenage mothers, refugee and new immigrant mothers and women from Asian and Taiwanese communities were also consulted. A range of representative groups were consulted including the Maternity Services Consumer Council, the National Council of Women, the Federation of Women's Health Councils, the Association for the Improvement of Maternity Services (AIMS), Parents Centre, the Country Women's Institute (CWI), and the Women's Division of Federated Farmers (WDFFF).

The National Health Committee found that the general level of satisfaction with maternity services was high among a large group of women, although there was room for improvement in the way they were informed about services. Consultation and other mechanisms for seeking consumer input into the review confirmed that the lead maternity carer principle operated well for most women and that women were now more involved than previously in planning their maternity care. "The advent of the single LMC responsible for co-ordinated care has made available to women the option of a close relationship with one person throughout the pregnancy, labour and birth, and postnatal period" (National Health Committee, 1999, p.59). The report also noted that the introduction of the responsibility placed on the LMC to develop a written care plan jointly with the pregnant woman was a valuable measure for maternal choice and participation in decision making. The report authors urged providers and their professional organisations to promote more participation in decision-making by women and to enhance more effective communication between providers through a more extensive use of care plans.

Several areas where there was scope for improvement were identified in the review. In particular, the issues of choice and information were dealt with repeatedly in the findings. Women identified a lack of independent and accessible information enabling them to make fully informed decisions about their maternity care. Some women were critical of information they found biased or confusing. A lack of accessible, culturally appropriate and understandable or timely information was reported by Pacific women. Most Maori women wanted an independent midwife LMC, preferably also Maori, but frequently encountered problems with inadequate provision of information about choosing an LMC. Submissions from consumer groups conveyed concern that some general practitioners, maternity groups, and Accident and Emergency clinics were charging women for maternity services. A bias or tension between

providers referring women to other services was frequently evident. Women expressed the desire to see doctors and midwives working more collaboratively. Communications between larger hospitals and smaller maternity facilities were mentioned as an area for improvement. Respondents also identified that communications relating to transfer between maternity carers and Well Child services required attention.

The Review noted that there has been a steady exit of general practitioners from the provision of primary maternity care in most areas and women's opportunity to choose a preferred provider has been limited accordingly. However, the National Health Committee was clear that it had not found the justification "to recommend significant new expenditure to reverse the changing makeup of the maternity service's workforce" (National Health Committee, 1999, p.5) Instead the report authors aimed to "consolidate, refine and render consistent what is already a workable and potentially equitable structure" (ibid).

The National Health Committee's 1999 review confirmed the validation of the core principles of the strategy devised by the Joint RHA maternity project following the original period of extensive consultation. At the same time, the Review acknowledged that "the very public expression of different views held by the key provider groups has undermined the confidence many women have in the safety and quality of maternity services in New Zealand" (National Health Committee, 1999, p.11). The following chapter explores examples of the public expression of these differing views, and discusses the influence of the consumer view on the changing nature of primary maternity services delivery in New Zealand.

Chapter 10: Discussion and Conclusions

Previous chapters have detailed how the principle of acceptability has been applied in recent years to that section of the New Zealand public which is attentive to the way maternity services are delivered. The model described in these chapters presented an applied answer to the question: "How can planners and funders involve the public in decisions about health services?" This final chapter addresses the companion question: "To what effect?"

Consumers of maternity services have been instrumental in effecting fundamental changes to maternity care delivery in New Zealand, and subsequently in the validation and retention of those changes. This study documents the mechanisms used to facilitate the consumer voice on either side of this period of major change. The facilitation and documentation of the consumer voice has contributed significantly to the creation and retention of a style of service delivery which addresses the needs of women within the budget available nationally for primary maternity services.

The original research objectives for this study were to ascertain whether or not women's satisfaction with maternity services changed following implementation of the new framework, and to identify particular aspects of service delivery where changing levels of satisfaction were evident. In general, the lead maternity carer system was evaluated positively by research participants. Satisfaction with most aspects of primary maternity care remained constant and high for each data collection period. For example, in 1995, 1997 and 1999, more than 90 percent of survey respondents either agreed or strongly agreed that the care they received during pregnancy suited their individual needs. Similarly, more than 85 percent of women for each data collection period either agreed or strongly agreed that the care they received during labour and birth suited their individual needs.

The study highlighted a significant measure of dissatisfaction with postnatal care. However, the greater part of the issues raised by women pertained to the care they received during their stay on a postnatal ward. This aspect of care was included in the research enquiry in order to provide a comprehensive context for the main research objectives, but it should be noted that staffing levels and other issues related to the care women received from postnatal ward staff stand outside the scope of the changes implemented through the *Notice* in 1996. The second aspect of concern highlighted for the postnatal period related to the quantity of home midwifery visits provided. This aspect is covered by the *Notice*, which stipulated for the first time the minimum number (five) of midwifery home visits women should receive. The research uncovered the fact that not all lead maternity carers are fulfilling this requirement. The

challenge for funders now is to make sufficient use of monitoring and audit provisions to ensure improved adherence to these specifications.

New Zealand women who were attentive to the issues surrounding maternity care had identified, well in advance of the introduction of the lead maternity carer framework, that continuity of carer for the maternity episode was key to an ideal service. This was a view they held in common with some of their international counterparts. For example, the United Kingdom Health Committee Report on Maternity Services (Department of Health, 1992) identified that women wanted continuity of care and that the majority of them thought the person to provide that care should be a midwife. Consumer input during the planning phase was not, however, sufficient of itself. The environment to which the new maternity services framework was introduced was a difficult and confrontational one, requiring a robust model with comprehensive opportunities for consumer evaluation of the new maternity arrangements over an extended time frame.

Challenges to the maternity reforms were usually related to the new payment arrangements. A key point was the lack of distinction between payment arrangements for general practitioners and independent midwives. Where midwifery only care is chosen by a pregnant woman, the midwife receives the modular payments in full. If a general practitioner takes on the LMC role, with hospital midwives providing the midwifery component of care during the labour, birth and postnatal periods, general practitioners receive a predetermined amount (the splitting out of the general practitioner's fee from the hospital midwifery fee formed part of the 1998 amendments to the 1996 *Notice*). However, where independent midwives and general practitioners jointly provide care, payments need to be worked out individually based on the degree of respective involvement in the woman's care.

New Zealand is not unique in experiencing a degree of controversy when maternity care for low risk women and associated payment arrangements are being reconsidered. General practitioner opposition to midwifery led care has recently been evident in the United Kingdom (for example, see Williamson and Thomson, 1996), and some UK general practitioners have been candid about their own financial interest in maternity care and how this colours their view of changing maternity services. Battersby (1994) reported that the general practitioners she interviewed expressed concern at the possible financial implications of the *Changing Childbirth* recommendations (Department of Health, 1993). One general practitioner "felt very nervous because she made a lot of money from maternity care," and others "were happy for midwives to take on the care unless it meant loss of income to their general practices" (Battersby 1994, cited in Williamson and Thomson, 1996).

In the run up to the 1996 implementation of the new maternity services framework in New Zealand, and in the weeks and months that followed, the merits and inadequacies of the maternity reform package were debated via the media frequently and with intensity. Doctors emphasised safety as a key issue in the media debate. Headlines such as *Maternity plan 'unsafe'* (*Southland Times* 16 February 1996) and *Pregnancy safety endangered - GP* (*Christchurch Press* 28 June 1996) were common. Details on how or why safety could be compromised were often linked to fees payment. For example, the safety related content of the article which ran under the *Maternity plan 'unsafe'* headline was as follows:

GP Association deputy chairman Branko Sijnja, of Balclutha, said yesterday doctors would be unwise to agree to work under the [new] system.... "The fees are set at a very low level and it is conceivable that the money will run out if a pregnancy has even minor complications," Dr Sijnja said. There were no allowances in the budget for extra investigations and treatment. Women with known risk factors might have difficulty finding a lead maternity carer, he said.

The safety issue was explained under the '*Pregnancy safety endangered*' headline as follows:

Dr Creegan said... doctors were concerned that the new system would make it more difficult for women to access the doctor they chose or all the services they needed. That could reduce safety for mothers and babies.

The new way funding was being distributed by the RHAs was inadequate to ensure safe, good-quality care for all women. It would also fail to encourage shared care where this was appropriate, and provide scans and other services that were required for a complicated pregnancy.

Bill Douglas, a Wanganui general practitioner, argued this point in a more direct manner when he decried the "ongoing RHA instituted fragmentation of general practice." The solution he offered was for the RHAs to "grasp the bull by the horns and acknowledge that the roles, expenses and areas of expertise of midwives and doctors are different and should be compensated for on different schedules" (NZ Doctor 26/6/96) Papps and Olssen (1997) comment on the wider context for this debate, contending that professional jealousy in the childbirth arena is frequently cloaked by the contestation of specific issues such as money or safety.

In the Christchurch Press article, "*Pregnancy Safety Endangered*" referred to above, obstetrician and gynaecologist Mike East refers to the unanimous agreement at a recent meeting of Christchurch doctors '*that the new arrangements were "scandalous and insulting" and "belittled the value of women". The idea of a fixed level of care was "ludicrous"*'. The 'idea' however, was not for a fixed level of care, but rather, for a fixed level of remuneration, with

care provided on the basis of need. East's argument is inaccurate, but certainly more powerful than arguing that the idea of a fixed level of remuneration is "ludicrous".

Alongside the safety issue, some doctors made vigorous use of the increasingly apparent reduction in choice of care arrangements, particularly in relation to shared care. The New Zealand Medical Association in particular embraced this argument, which was an interesting reversal from the stance they had taken three years earlier. In 1993 the NZMA had argued in its submissions to the Maternity Benefits Tribunal that it was an irresponsible use of public funds to pay both doctors and midwives to attend the same birth. They claimed that the uncapped fee for service system led to over servicing and was a waste of resources. Professor Hutton contended that shared care resulted in poor outcomes (Donely,1999).

The use of arguments relating to the reduction in choice for women post implementation of the new framework bear consideration alongside the findings related to choices for women in Chapter Six. Analysis of the 1995 data showed that the first health professional a woman made contact with (commonly her general practitioner) exerted a strong influence, whether subtle or overt, over her final choice of care arrangements. What was less clear, was to whom we should attribute the verb "choosing" as for many cases, the distinction was blurred between the woman's "choice" and the preference of the first health professional she made contact with.

In addition to ensuring widespread press coverage on the issues of safety and choice, doctors employed a range of other strategies in an attempt to have the maternity reforms overturned. A substantial segment of the general practitioner population boycotted the new structure by refusing to provide maternity services for women. A much smaller sector made their protest by charging women for maternity care. This aspect of the campaign was spearheaded by a group of Te Anau general practitioners. Dr Patrick O'Sullivan, one of four general practitioners based at the Fiordland Medical Centre argued that "RHAs won't see sense until women are speaking out about being charged"(*GP Weekly* p1 24 July 96). Te Anau women had no alternative, as there was no midwifery service in the area and the nearest base hospital is 160 km away in Invercargill.

While the debate was at its height, doctors added a new tactic - telling women not to get pregnant. Under the headline "*Hold off having babies: doctors*" the *New Zealand Herald* ran a story that began with the instruction "*Don't get pregnant just yet.*" Then followed:

That is what doctors advise couples planning parenthood in the light of a row over a new maternity care system introduced this month.

“GPs are advising those couples planning pregnancy that it might be better to wait a month or two before conceiving,” a spokeswoman for the Royal New Zealand College of General Practitioners, Dr Tessa Turnbull said yesterday.

It was clearly implicit in this statement that the Royal New Zealand College of General Practitioners expected the maternity reform package to be overturned almost immediately. This did not eventuate.

The vocal lobby from some sections of the medical profession, did, however, illustrate the need for a robust model for facilitating evaluative consumer input. Following comprehensive opportunities for consumer input, it was established that the lead maternity carer model for the provision of primary maternity care should be retained. With regard to the results of both consultation and consumer perception sampling, and alluding to the by then well established exit of general practitioners from primary maternity care, the National Health Committee, (as discussed in Chapter Nine) reported that they had not found justification “to recommend significant new expenditure to reverse the changing makeup of the maternity service’s workforce” (National Health Committee, 1999, p.5). The reference to “significant new expenditure” is key. The inevitable boundaries of fiscal constraint create a challenging environment for decision making about publicly funded health services. Many health professionals and health service funders are wary of introducing a strong element of consumer participation to the decision making table as they fear this will introduce an unrealistic “wish list” element to health service planning. Consumer comment on the 1996 maternity reforms was however, generally characterised by an awareness of the funding constraints. For example, in a story run by the *New Zealand Herald* two days after the 1996 *Notice* was introduced, one recent mother commented that “*It has taken away choice*” while at the same time acknowledging that “*in an ideal world, it would be really good to have that [old] system but New Zealand doesn’t have that money.*”

It is well established that child bearing women do want to participate in decision making about maternity care, both individually and collectively. A very similar set of drivers is operating at both a micro and a macro level. On the one hand, individual maternity care consumers repeatedly say, both in the surveys and interviews reported in this thesis and elsewhere internationally (for example see Webster, Forbes, Foster, Thomas, Griffin and Timms 1996; Wilcock et al., 1996; Pelkonen, Perälä and Vehviläinen-Julkunen 1998), that the fundamental priorities are the need for more information and increased opportunities to be involved in decision making about their care. Continuity of care is often preferred (for example see Handler, 1996; Zadoronyj, 1996; Kerslake Hendricks, 1999; Farquhar, Camilleri-Ferrante and

Todd, 2000), not least because it facilitates the meeting of these two requirements. Information and decision-making are integrally linked since the more informed women are, the more robustly they will enter into decision making processes. The same is true of the collective decision making entered into by communities of maternity consumers. In an optimal environment, childbearing women will collectively be well informed about forthcoming policy and funding decisions, and will have adequate avenues for participating in those decisions.

The model described in this thesis has a number of factors critical to its success as well as some aspects which could be improved on in any future applications of the model. The first of the success factors is the fact that women were consulted early in the planning cycle, after identification of the problem, but before any conceptualisation of the solution. Secondly, a baseline of consumer perceptions of the service was established prior to the implementation of changes, to allow a genuine opportunity for comparative evaluation. Thirdly, women's views were sought over an extended time frame through a variety of mechanisms, and fourthly, there was consumer representation at the negotiating table at the time when key decisions about the detail of the new framework were being agreed. This last factor, while contributing to the success of the overall model in this instance, also left considerable room for improvement in future applications of the model. Ideally, consumer representation for decision making forums such as the negotiations which took place concerning the detail of the new maternity services framework in 1995 and 1996, should be planned for and facilitated by the funders and policy makers. As discussed in Chapter Five of this thesis, consumer representation in this application of the model occurred by virtue of the New Zealand College of Midwives' commitment to its underpinning philosophy concerning consumer participation rather than being funder initiated. As a result, there was only opportunity for one consumer to attend most of the negotiations. As discussed in Chapter Three, Parboosingh et al (1997) describe a preferable scenario for consumer representation in relation to Canadian regional breast cancer information exchange projects. Women affected by breast cancer constitute 50 percent of the membership of the Advisory Committees which provide direction to each project.

Overall, the model proposed here falls on a midpoint of the participatory continuum that spans market driven consumerist approaches through to fully democratic approaches. It is specific to the purpose of a defined service review, and therefore is appropriately focussed on the users of the particular service. Its mechanisms vary from data collection to empowerment activities. The value of the model lies in both the variety of mechanisms employed, and the practical and applied focus of the model.

The model for consumer participation and the issues discussed here are not limited in terms of their applicability to maternity services. There is a much wider debate about the value of consumer and community input into health services generally.

An Australian resource guide, designed to facilitate the involvement of consumers in health service planning and evaluation, provides the following commentary in response to the question: “What can a consumer tell us that we don’t already know?”

Consumers are the experts on how treatment and other services are received and experienced. They can tell you about how different social and environmental settings impact on the effectiveness of services. They can tell you why some services get used and others don’t. They can tell you how it feels to be on the other side.

But this is only one part of the value of involving consumers. The point is not just what we as providers can learn from consumers. Rather it is about how we can work with consumers as co-producers of health outcomes, or partners in health development. That means consumers take on a more active role in their own health care and in the planning, implementation and evaluation of health care services. In that role they are informed by their own experiences and networks, and by the expert knowledge of providers. Providers also change their role in response to information from consumers so as to make services more appropriate to consumer needs and preferences. The result is a win-win situation, with more responsible, empowered and healthy consumers and wiser, more grounded and outcomes-focused providers.

(Consumer Focus Collaboration, 2000, p.129)

However, Hilda Bastian, chairwoman of the Australian Consumers Forum believes that consumer participation in developing health policy and health service planning and provision is still in its infancy most countries:

Lay input into health care decision making is largely tokenism, she says. The lay voice in expert committees is usually represented by a single person, who is easily intimidated by a team of health professionals. Furthermore, the invited individual is often not aligned with a group of consumers and may lack advocacy skills. As a result it is easy to discount his or her views. (Coulter, 1999, p.719).

There is certainly scope for improvement in the processes and models which are widely used to facilitate consumer input for health services policy and planning, but even though the practice is as Ms Bastian describes it, largely still in its infancy, there are a number of individual success stories. For example, the Emergency Department (ED) of the Lyell McEwin Hospital in Adelaide’s northern suburbs initiated a project in 1998 that aimed to give ‘a voice to the community’. Using many consumer participation tools, people of all ages and walks of life had a say about what ED could do better. As a result, the ED staff have shifted their approach to care, improved the waiting room facilities, established a consumer advocacy group, undergone

cultural awareness training and worked more closely with outside community groups. One of the key outcomes has been that complaints have dropped by 80 percent, compared with the previous 12 month period (Stuart and Parker 1999).

The following excerpt from a letter response to a recent BMJ editorial speaks to the success of community participation while highlighting the distinction between a micro and a macro approach to the supply of information and shared decision making. Crowley comments on a tradition of work in the UK which has nurtured the role of local communities in influencing their health policy and in creating and pursuing their own health agenda:

This tradition entails a shift from an individual illness based model to a collective model that is concerned with addressing the underlying determinants of ill health. This approach is exemplified by work in west Newcastle over the past five years, where the locality group and the primary care group have funded an independent community development project that is directed by a committee of representatives from the local community. The approach maintains a constant focus on health inequalities and challenges discrimination. Its work with minority groups was recognised last year with an NHS equality award. A recent evaluation of this initiative showed that the community development approach has been successful in creating and sustaining links with a large number of local community groups and individuals, and important innovations have resulted, as have changes in people's commitment to meeting the needs of minority groups. (Crowley, Letter BMJ 2000; 320:117)

Internationally there is considerable momentum as well as considerable scope for improvement in the way health policy makers and planners are applying the World Health Organisation's Alma Ata Declaration regarding the right and duty of people to participate individually and collectively in the planning and implementation of their health care. This vision has gained a hold in the discourse of politicians and policy makers. Dr Michael Wooldridge, the then Minister for Health and Family Services, Australia, made the following comments in 1997:

One of the most important changes occurring in Australian health care today is a long overdue shift away from a disproportionate focus on providers – on hospitals, doctors and insurance companies – and on to the most important people, those who need hospital and medical care For too long the very people who matter most in hospital care have been treated merely as passive recipients of care rather than as people with rights who can and should be consulted and actively involved in the treatment and care they receive (Draper, 1997, p.vii).

In New Zealand, the Labour Government, upon taking office in 1999, set about restructuring the health sector in a bid to make health funding bodies more responsive to their local communities. It was envisaged that the elected membership of District Health Boards will help ensure democratic participation in the decision-making process, as an adjunct to other mechanisms for facilitating community and consumer participation in decision-making. *The New Zealand*

Health Strategy, released by the Minister of Health in December 2000 promoted active involvement of consumers and communities at all levels in the health sector as one of its seven key principles (King, 2000).

This emphasis on consumer and community participation will increasingly become an unavoidable necessity for politicians, policy makers, health planners and managers. The forces driving reform during the 1990s in New Zealand and common to most Western nations will soon be operative globally. Decision makers in the health arena will come to rely on mechanisms such as the model outlined in this thesis in order to plan effectively, educate and inform the public, and achieve decision making which is sanctioned by communities, against the backdrop of inevitable fiscal constraints and burgeoning demand and competing priorities for public health funding.

It will also become increasingly important to document and evaluate the use of different kinds of models for consumer participation in service redesign. The model proposed and described in this thesis, (consisting of prospective and retrospective consultation, consumer representation during the process of detailed and final decision making, and a longitudinal sampling frame for consumer perceptions which includes pre and post implementation phases) can be applied to other settings and/or in relation to other major service reviews.

However, part of the ease of applicability of this model related to the fact that maternity has well established consumer groups with both regional foci and national networks. Many other service areas which do not have such well established consumer networks would nonetheless benefit from the application of this model where major service reviews are planned. It is therefore recommended that the Ministry of Health establish a national consumer resource centre in order to enhance networks among existing consumer groups and facilitate consumer input into health service planning and evaluation.

The study reported in this thesis makes a unique contribution to the body of knowledge concerning consumer participation and influence in establishing priorities for the provision of publicly funded maternity services. This contribution would be enhanced by the application of this model to other health service contexts, coupled with evaluations of its effectiveness in these settings. These activities are suggested as productive prospects for future research.

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Appendix 1: Ethics Approval Letters



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**FACULTY OF
BUSINESS STUDIES**

DEPARTMENT OF
HUMAN
RESOURCE
MANAGEMENT

19 December 1994

**Joy Christison
Department of Management Systems
MASSEY UNIVERSITY**

Dear Joy

Thank you for your amended information sheet and consent form. The amendments meet the requirements of the Human Ethics Committee and the ethics of your project is approved.

You should now seek the approval of the relevant Area Health Board.

Yours sincerely

**Professor Philip Dewe
Chairperson
Human Ethics Committee**

HAWKE'S BAY ETHICS COMMITTEE

CENTRAL REGIONAL HEALTH AUTHORITY

20 January 1995

Joy Christison
Department of Management Systems
Massey University
Private Bag 11222
PALMERSTON NORTH

Dear Ms Christison

This is to confirm that the Hawke's Bay Ethics Committee has considered the application entitled "Consumer Evaluation of Maternity Service Provision in the Central Region" and approval has been given to the study. An approval number will be allocated under separate cover.

Yours faithfully



S P Lunn
A:955

Copy to: Bibby Plummer
Chairperson
Manawatu Wanganui Ethics Committee of
Central Regional Health Authority
P O Box 5203
PALMERTON NORTH

Kathy Shanahan
Private Bag 6023
Napier

MANAWATU WANGANUI ETHICS COMMITTEE

P O Box 5203
Palmerston North

Room 7, Rimu Hostel
Palmerston North Hospital

Phone/fax: 0-6 356 7773

CENTRAL REGIONAL HEALTH AUTHORITY

30 March 1995

Ms Joy Christison
15 Union St
PALMERSTON NORTH

Dear Joy

Ethics Register 1/95: Consumer Evaluation of Maternity Service Provision in the Central Region

Thank you for your amended documentation for this study. We are pleased to give full ethical approval for your study to commence in the Manawatu-Wanganui area.

I would advise that the Ethics Committee makes decisions on ethical issues only. We note your study is to be carried out in the Manawatu area. You are therefore required to obtain written approval from the Chief Executive Officers, MidCentral Health Ltd and Good Health Wanganui, for your study to commence. If you require any finances and/or resources for this proposal you are required to inform the Chief Executive Officer accordingly.

Please note, this study is approved for a two year period in the Manawatu and Wanganui area only, and re-approval is required after that time. There is a short form to be completed when requesting reapproval, which is available from the Committee Co-ordinator.

Finally, the Ethics Committee requires you to submit a progress report on the study within twelve months, and at the completion of the study a copy of any report and/or publication for its records. Please notify the Committee if your study is abandoned or the protocol changed in any way.

Copies of your amended documentation have been forwarded to the Wellington Ethics Committee (who are responsible for the Nelson-Marlborough region also) and the Hawkes Bay Ethics Committee. The Hawkes Bay Ethics Committee, as you know, has already given full ethical approval for this study in the Hawkes Bay area. The Wellington Ethics Committee have been asked to notify this Committee of their final decision within 14 days, as per the multi-centre process for ethical approval, and we will let you know their decision.

We wish you every success with this study.

Yours sincerely



Bibby Plummer
CHAIRPERSON

c.c. Mrs Margot Mains, CEO, MidCentral Health, and Mr Ron Janes, CEO, Good Health Wanganui

MANAWATU WANGANUI ETHICS COMMITTEE

P O Box 5203
Palmerston North

Room 7, Rimu Hostel
Palmerston North Hospital

Phone/fax: 0-6 356 7773

CENTRAL REGIONAL HEALTH AUTHORITY

23 April 1995

Ms Joy Christison
15 Union St
PALMERSTON NORTH

Dear Joy

Ethics Register 1/95: Consumer Evaluation of Maternity Service Provision in the Central Region

This letter is to confirm that you have ethical approval for your study to commence in the Wellington and Nelson-Marlborough region under the same conditions as in our letter to you of 30 March giving ethical approval for the Manawatu-Wanganui area.

Yours sincerely



RP Mrs Bibby Plummer
CHAIRPERSON

c.c. Ms Alison Douglass, Chair, Wellington Ethics Committee

MANAWATU-WHANGANUI ETHICS COMMITTEE

CENTRAL RHA
TE IHONGA HAUORA



Chairperson **Dr Audrey Jarvis**
e-mail jarvis@manawatu.gen.nz

Secretary **Ms Vicki Graham**
e-mail mwethics@manawatu.gen.nz

29 April 1997

Ms Joy Christison
15 Union St
PALMERSTON NORTH

Dear Joy

Ethics Register 1/95: Consumer evaluation of maternity service provision in the Central region

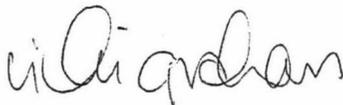
Thank you for your progress report on this study, which was received at the Committee's meeting last week.

The Committee is pleased to issue a further two year approval of the study, with the usual proviso that annual reports are submitted.

The Committee will suggest to the other Ethics Committees involved that they issue reapproval for a similar period.

Kind regards.

Yours sincerely



Dr Audrey Jarvis
CHAIRPERSON

Room 214, Matai Hostel, Palmerston North Hospital

PO Box 5203, Palmerston North

Telephone/Fax: 06 356 7773

Appendix 2: Examples of Correspondence with Crown Health Enterprises

14 March 1995

FILE COPY

**CENTRAL
REGIONAL
HEALTH
AUTHORITY**

Dear

Central RHA has recently confirmed a contract with Massey University to evaluate maternity services in our region from the consumers' perspective. The researcher who will undertake this research over a three year period is Joy Christison. She will be working directly with providers, professional groups and consumers throughout the research period to gather information on the consumer evaluation approaches being used and women's satisfaction with the services they receive.

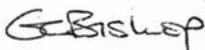
There will be occasions in which we will be asking for your assistance with the research. In May of each year we would like your assistance to distribute a survey form to all women who have their babies in your hospitals. We will not be asking you to collect the forms from the women although we would like to discuss with you how this could be facilitated, for example by having a collection box in a common area in your postnatal wards. More detailed information will be made available and the survey issues will be discussed with you once a pilot survey has been undertaken.

During a specified week in June 1995 and 1996 we will again be seeking your cooperation to distribute a package to all women who have their babies in your hospitals to request their participation in an interview to seek feedback on their maternity care. Central RHA and the researcher will assist you to ensure that all women and their providers are aware of the reasons for the surveys and to ensure the information gathering has as little impact on the work of your staff as possible.

I am very pleased that we will be able to evaluate the effect of the introduction of changes in maternity services over this critical period and that the evaluation will include the perceptions of the women who are using the services. If you have any queries about the research or would like more information please ring me on (04) 495 2153.

Thank you in anticipation of your cooperation,

Yours sincerely



Gillian Bishop
PROJECT MANAGER (CONTRACTS)

Level 12, 155 The Terrace, PO Box 10 097, Wellington. Phone (04) 472 7633, Fax (04) 472 7639

Joy Christison
Management Systems
Massey University
Private Bag 11 222
PALMERSTON NORTH

Mr John Peters
Chief Executive Officer
Wairarapa Health
Masterton Hospital
PO Box 96
MASTERTON

25 April 1995

Dear John,

Re: Approval for Research Project - Consumer Evaluation of Maternity Service Provision in the Central Region

This CRHA funded study was given full ethical approval by the Manawatu-Wanganui Ethics Committee on 30 March 1995 and I received confirmation of approval from the Wellington Ethics Committee on 23 April (see enclosed). I am now writing to request your written approval for the project to commence in your CHE.

The project will involve a yearly survey of maternity clients in the Central Region and some in-depth interviewing. An executive summary, a copy of the full proposal and a draft of the survey form are enclosed.

The proposed timeframe for the survey is May 15 through to June 11. No request is being made for CHE finances for this project although a request to CHE maternity managers has been made by Gillian Bishop (Contracts Manager, CRHA) for assistance from CHE staff to distribute survey packs in May of this year.

If you have any further queries please leave a message with the Management Systems secretaries (06 - 350 5194) and I will return your call as soon as possible.

Thank you for your consideration of this matter.

Yours sincerely,



Joy Christison

cc. Gillian Bishop, CRHA

Appendix 3: Interview Documentation

WHAT WOMEN HAVE TO SAY ABOUT MATERNITY SERVICES

Kia ora, kia orana, talofa lava, malo e lelei, taloha ni, fakalofa lahi atu, ni sa bula, namaste, hello -

Congratulations on the birth of your new baby! Because you had your baby between June 26 and July 2 in the Central region, you're part of a group of women we'd like to hear from. We're hoping to interview a range of women from a variety of backgrounds between July 31 and August 18 (when your baby is somewhere between 5 and 7 weeks old). This is part of a research project on maternity services which is funded by the Central Regional Health Authority and supervised by senior staff at Massey University. It is up to you whether or not you take part but if you do you will be helping to shape the thinking of the Central RHA and many maternity service providers in the Central region. If you don't, it will not make any difference to your maternity care.

If you do agree to take part, your interviewer will visit you at home (or another place chosen by you) at a time that suits you. Interviews will take about an hour and will be tape recorded if you are happy with this. The questions will be about the maternity services that were provided for you and your baby. If there's a question you don't want to answer, it's fine to say "I don't want to answer that one." Also, you can choose to stop the interview at any time if you want to. We want to hear from rural women too, so don't think that we won't want to come if you live a long way out of town. We're happy to travel, and we do want to hear your views.

If you are happy to consider being interviewed, please fill in the slip below and return it in the freepost envelope provided. It would help a lot with our planning if you could post it by July 9. Or you can give these details by calling Joy Christison on the freephone 0800 181 222, 7 pm - 10 pm from June 26 to July 9. Your interviewer will write to you to let you know a bit about herself, and send you more information about the interviews. Then, if you are happy to continue, your interviewer will arrange a time with you for the interview.

If you have any questions about this research project, you can talk them over with Joy during the freephone times.



WHAT WOMEN HAVE TO SAY ABOUT MATERNITY SERVICES

Yes, I'm happy to consider being interviewed.

Name:

Address:

.....

.....

.....

Phone:

I would like to be interviewed by a: Pacific Island Maori European/ Pakeha interviewer



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**FACULTY OF
BUSINESS STUDIES**

**DEPARTMENT OF
MANAGEMENT
SYSTEMS**

CONSUMER EVALUATION OF MATERNITY SERVICE PROVISION IN THE CENTRAL REGION

Information Sheet for Interview Participants

Who is the researcher?

Joy Christison, Ph.D. student, Massey University.

Where can she be contacted?

At home:	15 Union Street Palmerston North	or	Management Systems Massey University Private Bag 11 222 Palmerston North
	phone: (06) 356 9790		phone: (06) 356 9099 x 4308

Who are the researcher's supervisors?

Prof. Tony Vitalis Management Systems Massey University Private Bag 11 222 Palmerston North	Nicola North Management Systems Massey University Private Bag 11 222 Palmerston North
phone: (06) 350 4388	phone: (06) 350 4378

What is the study about?

This study is concerned with consumer evaluations of maternity services in the Central Region. Consumer evaluations are being sought in two ways. Firstly there will be two broad based surveys (one in 1995 and one in 1997) of women who have given birth within a specified time frame. It is assumed that by filling in the questionnaire the participant consents to taking part in this aspect of the research. Secondly, number of face to face interviews with women will be carried out throughout the region to allow for a fuller exploration of key issues.

(continued over ...)

What will interview participants be asked to do?

If you choose to take part in the interview, the interviewer will come to your home or another place chosen by you, at a time that suits you. The interviewer will ask about the maternity care you received and there will be time for you to talk about aspects of your own experience that may not have been discussed during the interviewer's questions.

How much time will it take?

Approximately one hour.

If you take part in the study, you have the right to:

- * refuse to answer any particular question, and to withdraw from the study at any time
- * ask any further questions about the study that occur to you during your participation
- * provide information on the understanding that it is completely confidential to the researchers. It will not be possible to identify you in any reports that are prepared from the study.
- * be given access to a summary of the findings from the study when it is finished.



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FACULTY OF BUSINESS STUDIES

DEPARTMENT OF MANAGEMENT SYSTEMS

PARTICIPANT CONSENT FORM

Project title: Consumer Evaluation of Maternity Service Provision in the Central Region

Principal researcher: Joy Christison

Participant's Name:

1. I have read the Information Sheet for this research project and my questions about the project have been answered to my satisfaction. I understand that I can ask more questions at any time.
2. I understand that I am free to stop the interview at any time, or decide not to answer some of the questions.
3. I agree to provide information to the researcher on the understanding that it is completely confidential, and that my name will not be used in any written or verbal reports about the study.
4. I do/ do not consent to my interview being audiotaped. I understand that if I do agree to audiotaping, I will receive a transcript of the interview and will be able to cross out any part of the interview that I do not want to be used in any way. I understand that the transcriber who types up my interview will be required to sign a confidentiality statement before starting work. When the tape of my interview is no longer required I would like it to be erased/returned to me at the following address:

.....
.....
.....

5. I understand that if I have any concerns about this project, I can contact the Manawatu- Wanganui Ethics Committee on (06) 356 7773, or the Wellington Ethics Committee on (04) 3855 999 ext. 5185.

I agree / do not agree to take part in this interview.

Signature:(participant).(date)

Interviewer's statement:

I have discussed with the aims of this project and the interview process.

Signature:..... (interviewer).(date)

..... (name of interviewer, please print)

SUGGESTIONS FOR INTERVIEWERS.

Some guidelines and suggestions are provided below but if women suggest other topics or a particular question gets them started on a lengthy account of some aspect of their experience, then it's fine to go with that and abandon some of the other questions. Also if you don't feel comfortable asking a particular question just miss it out.

Topics to be raised ideally in each interview.

- Access to information about choices in maternity care.
- Participation in the decision making process regarding care arrangements for themselves and their babies.
- Ease of communication with health professionals.
- Degree of satisfaction with care provided by health professionals.
- Quality of advice offered postnatally on a range of topics. E.g. feeding and caring for your baby, care of the fundus and perineum, prevention and detection of breast infections, coping with the demands of parenting, postnatal depression.

Question Examples

Please remind women before beginning that it's OK to choose not to answer some questions.

Section one : personal details.

Was this the first time you have given birth?

If no, how many times have you given birth before ?

How old are you (roughly) 15-20, 21-25, 26-30, 31-35, 36-40, over 40 ?

Were you born in New Zealand?

If no, how long have you been living in New Zealand?

Which ethnic group or groups do you feel you belong to?

Did you complete any qualifications after leaving school?

If yes, which qualifications?

Which of these descriptions applies to your present living arrangements:

Married

De facto -living together

Separated

Divorced

Widowed

Never married

Section two : your experience of the maternity services that were provided for you.

While you were pregnant....

Did you get information or advice from any of these organisations?

Parents Centre
 La Leche League
 Home Birth Association
 A local Women's Health Collective
 Some other organisation not listed here

How useful was the advice or information?

Did you go to antenatal classes?

If yes, who organised the classes?

Hospital

Parents Centre

Home Birth Association

Some other organisation

Did you choose your own midwife and/or doctor?

Did you choose to go to a specialist?

How many weeks pregnant were you when you had your first pregnancy related visit with a health professional?

Did the health professionals you saw at the beginning of your pregnancy give you information about other health professionals and other maternity care arrangements that were available to you?

Can you remember whether you ever felt you would have liked to ask the midwife or doctor or specialist about something, but didn't?

Did a doctor or midwife or specialist discuss a care plan with you at any stage? (A care plan is a plan of the kind of care that will best suit your needs during pregnancy, labour, birth and the postnatal period.)

How much say did you feel you had about what was in the care plan?

How many times did you see a health professional during your pregnancy?

Did you think that was the right amount for you?

Did the care you got during pregnancy suit your needs?

Labour

How did you know that labour had started for you?

At what stage did you call your midwife or go to hospital?

What sort of response did you get from your midwife?
How were you greeted when you arrived at hospital?

How many different health professionals looked after you during labour?

Was your partner/support person/whanau well accepted by the health professionals who were caring for you?

How much did you know about what was going on during labour?

Who gave you the most information?

Did you ever ask for something to be explained to you or ask why something was being done?

How did you feel about the reasons or explanations that were given?

Did you ever feel you wanted to ask something but didn't?

Did you ever feel under pressure to agree to something?

Did you find labour very painful?

Did you have any form of pain relief?

Did that kind of pain relief that you were given suit your needs?

Do you think you had the right amount of pain relief?

Can you think of any changes health professionals could make to the way they do or say things during labour that might make it better for other mothers?

Birth

Where did you give birth? (home/labour room /delivery room/on the way to hospital)

What position were you in when you gave birth (standing/hands and knees/squatting/supported squat/semi-reclined/lying on side/lying on back/)?

Did you choose this position?

Did a health professional suggest or request a position?

How did you feel about that?

Was anything done to help the baby out?

Was this discussed with you or explained to you beforehand?

How long after the birth were you first able to hold the baby? (before or after the cord was cut?)

How did you feel about giving birth at the time? and now?

During the time after your baby was born...

Did you get helpful advice about feeding your baby?

Who did you get helpful advice from?

Did you get good advice about how to look after yourself?

- How long the bleeding could be expected to last?
- What to do if the bleeding suddenly got heavier?
- How to look after your stitches if you had any?
- How to tell if you were getting a breast infection?

Who did you get this information from?

Did a health professional give you useful information about caring for your baby, and what to expect as the parent of a newborn?

If you had your baby in hospital, how did you feel about going home with your baby?

Was the timing right for you?

Did anyone explain the baby blues and postnatal depression to you?

Did you know that there were support groups available for mothers with postnatal depression?

Did anyone give you or show you a copy of your own obstetric record?

Did anyone tell you that you could see a copy if you wanted to?

Were you given an evaluation or feedback form to fill in? Who by?

Was there any other way that individual health professionals or a provider organisation (e.g. your local hospital) asked for your opinion about the quality of care you received?

Was there any time during your pregnancy, birth or afterwards that you felt a health professional was too busy to attend to your needs?

If you were to have another baby, do you think you would do anything different next time?

Appendix 4: Survey Forms

Appendix 4A: 1995 information sheet and survey form

Appendix 4B: 1997 information sheet and survey form

Appendix 4C: 1999 information sheet and survey form

Facsimile 06-350 5661


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**CONSUMER EVALUATION OF MATERNITY SERVICE
PROVISION IN THE CENTRAL REGION**
Survey Information Sheet
Who is the researcher?

Joy Christison, Ph.D. student, Massey University.

Where can she be contacted?

At home: phone: (06) 356 9790	15 Union Street Palmerston North	or	Management Systems Massey University Private Bag 11 222 Palmerston North phone: (06) 350 5194 (Dept. Secretary)
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Who are the researcher's supervisors?

Prof. Tony Vitalis Management Systems Massey University Private Bag 11 222 Palmerston North phone: (06) 350 4388	Nicola North Management Systems Massey University Private Bag 11 222 Palmerston North phone: (06) 350 4378
---	---

What is the study about?

This study is concerned with what mothers think about maternity services in the Central Region. Mothers' opinions are being asked for in two ways. The first of these is a survey of all women who have a baby in the Central region in the May/June survey period of 1995, 1996 and 1997. Secondly there will be face to face interviews with a number of women who have a baby in the Central region in one week of June 1995 and 1996.

It is your choice whether or not you fill in this survey and your health care will not be affected if you choose not to. If you object to any particular question, just miss it out.

If you have any concerns about ethical aspects of this study you can contact the Manawatu-Wanganui Ethics Committee, PO Box 5203, Palmerston North, telephone/fax (06) 356 7773.

WHAT WOMEN HAVE TO SAY ABOUT MATERNITY SERVICES

Kia ora, kia orana, talofa lava, malo e lelei, taloha ni, fakalofa lahi atu, ni sa bula, namaste, hello -



Joy, with younger son, Samuel

My name is Joy Christison and I have two children, aged 11 and 3. I'm interested in finding out what women in the Central region think about the maternity care they have received. This survey is part of a PhD project at Massey University and is funded by the Central Regional Health Authority. You have been given this survey form because you had a baby in the Central region in the May/June survey period for this year. If you fill out this survey you will be helping to advise the Central Regional Health Authority and local providers on how to improve maternity services in our region.

Of course you can choose not to fill out this form, but I hope you will take this opportunity to have your say. If you object to, or don't understand any question, just miss it out. Don't write your name anywhere on this survey form. Your survey form will not be read by anyone other than myself or my research supervisors.

SECTION 1

Please tick one or more boxes as appropriate

1. Was this the first time you have given birth?
 YES NO
2. Where did you plan to have this baby?
 In hospital
 At home
 Other
3. Where did you have this baby?
 In hospital
 At home
 Other
4. Was the birth of your baby:
 Straightforward vaginal
 With forceps
 With ventouse (vacuum)
 By Caesarean section
 Not sure
5. When you first found you were pregnant, which of these choices did you know about?
 Receiving most of your care from a GP. (A GP is a General Practitioner, or family doctor)
 Receiving most of your care from a midwife
 Shared care between your GP and a midwife
 Shared care between a midwife and a specialist
 Receiving most of your care from a specialist
 Receiving care from a hospital team
 All of the above
 Didn't know I had any choice
6. Did you get more information about your choices at any stage during your pregnancy?
 YES NO
7. Did the first health professional you saw let you know that you could choose other health professionals to provide your maternity care? (By health professional I mean a midwife or doctor or nurse or specialist).
 YES NO
8. Did one or more of your health professionals discuss a care plan with you at any stage during your pregnancy? (A care plan is a plan of the kind of care that will best suit your needs during pregnancy, birth and afterwards).
 YES NO
 If YES, was the care plan written down?
 YES NO
 If YES, did you keep a copy?
 YES NO
9. About how many times did you see a health professional during your pregnancy?
 0-5 6-10 11-15
 16-20 More than 20
10. Did you see one health professional as having overall responsibility for your maternity care?
 YES NO
 If YES, which one?

11. Who provided care for you and your baby during your pregnancy?

- 1 Own midwife
- 2 Own GP
- 3 A GP other than my usual one
- 4 Nurse(s)
- 5 Hospital doctor
- 6 Hospital midwife(s)
- 7 Hospital specialist
- 8 Private specialist
- 9 Other (please specify):

12. Who provided care for you and your baby during labour and birth?

- 1 Own midwife
- 2 Own GP
- 3 A GP other than my usual one
- 4 Nurse(s)
- 5 Hospital doctor
- 6 Hospital midwife(s)
- 7 Hospital specialist
- 8 Private specialist
- 9 Other (please specify):

13. Who provided care for you and your baby after the baby was born?

- 1 Own midwife
- 2 Own GP
- 3 A GP other than my usual one
- 4 Nurse(s)
- 5 Hospital doctor
- 6 Hospital midwife(s)
- 7 Hospital specialist
- 8 Private specialist
- 9 Other (please specify):

14. Have you ever attended antenatal classes?

- 1 YES 2 NO

15. If you answered YES to Q. 14, who organized the antenatal course?

- 1 Hospital
- 2 Parents Centre
- 3 Home Birth Association
- 4 Other (please say who):

SECTION 2

For this section please indicate how much you agree or disagree with the following statements by circling one of the numbers. Choose your number for each statement using the scale below. If a question does not apply to you, circle the 0 in the "does not apply" column.

strongly disagree disagree neither agree nor disagree agree strongly agree does not apply
 1 2 3 4 5 0

Please circle one number for each question

strongly disagree strongly agree does not apply

PREGNANCY

15. The care I received during my pregnancy suited my individual needs.	1	2	3	4	5	0
16. I had the right amount of visits with a health professional	1	2	3	4	5	0
17. I think I had more visits with a health professional than I needed	1	2	3	4	5	0
18. I think I needed more visits with a health professional than I got	1	2	3	4	5	0
19. It was easy to ask my GP questions about my pregnancy	1	2	3	4	5	0
20. It was easy to ask my midwife questions about my pregnancy	1	2	3	4	5	0
21. It was easy to ask my specialist questions about my pregnancy	1	2	3	4	5	0
22. I got good information about different options for labour and birth	1	2	3	4	5	0
23. I was encouraged to plan what I wanted for labour and birth	1	2	3	4	5	0

Any other comments about this section:

.....

LABOUR AND BIRTH

	<i>strongly disagree</i>		<i>strongly agree</i>		<i>does not apply</i>	
24. I felt I was involved with decisions that were made about my care while I was in labour	1	2	3	4	5	0
25. I felt it was fine to ask questions whenever I wanted to	1	2	3	4	5	0
26. I got good explanations about what was happening	1	2	3	4	5	0
27. My support people/ whanau were made to feel welcome	1	2	3	4	5	0
28. My wishes regarding pain relief were respected	1	2	3	4	5	0
29. I needed more pain relief than I was given	1	2	3	4	5	0
30. I was given more pain relief than I needed	1	2	3	4	5	0
31. I felt there was disagreement between two or more of the health professionals involved in my care	1	2	3	4	5	0
32. I had enough privacy during labour	1	2	3	4	5	0
33. I had enough privacy at the time my baby was born	1	2	3	4	5	0
34. I had confidence in <u>all</u> the health professionals who were providing care for me and my baby	1	2	3	4	5	0
35. I had confidence in <u>at least one</u> of the health professionals who were providing care for me and my baby	1	2	3	4	5	0
36. The care I received during labour and birth suited my individual needs	1	2	3	4	5	0

Any other comments about this section:

.....

AFTER YOUR BABY WAS BORN

37. I was happy with the standard of care my baby received	1	2	3	4	5	0	
38. I got helpful advice about coping with the demands of a newborn baby	1	2	3	4	5	0	
39. I got good advice about how to look after myself after the birth	1	2	3	4	5	0	
40. I felt I got good support from at least one health professional	1	2	3	4	5	0	
41. A health professional gave me good information about the emotional ups and downs that can happen after having a baby	1	2	3	4	5	0	
42. The care I received after my baby was born suited my individual needs	1	2	3	4	5	0	
43. Before your baby was born how had you planned to feed your baby? <input type="checkbox"/> breastfeed <input type="checkbox"/> bottle feed <input type="checkbox"/> both							
44. I got conflicting advice about feeding from different health professionals	1	2	3	4	5	0	
45. I got helpful advice about feeding from a health professional	1	2	3	4	5	0	
46. If you got helpful advice about feeding from a health professional who did you get it from? <input type="checkbox"/> Own midwife <input type="checkbox"/> Hospital midwife <input type="checkbox"/> Hospital nurse <input type="checkbox"/> GP <input type="checkbox"/> Other (please say who):							
47. Did a health professional give a bottle or formula to your baby?	<input type="checkbox"/> YES						<input type="checkbox"/> NO
48. If YES, did they check with you first if this was OK?	<input type="checkbox"/> YES						<input type="checkbox"/> NO

Any other comments about this section:

.....

SECTION 3

49. Was there ever a time when you felt a health professional was too busy to attend to your needs?

¹ YES ² NO

If YES, please explain:

.....

50. If you were to have another baby, would you do things differently next time? ¹ YES ² NO

If YES, please explain:

.....

Are there any other comments you would like to make? (Please continue on the extra page if you need to).

.....

SECTION 4

I'm asking the questions in this last section so that I will know if the survey responses include the views of a broad range of women and so that I can identify preferences for different types of care.

51. Please tick which ethnic group/s you feel you belong to?

- ¹ NZ European/ Pakeha
- ² NZ Maori
- ³ Cook Island Maori
- ⁴ Niuean
- ⁵ Tokelauan
- ⁶ Samoan
- ⁷ Tongan
- ⁸ Other Pacific Island
- ⁹ Chinese
- ¹⁰ Indian

¹¹ Other (please specify):

52. Were you born in New Zealand?

¹ YES ² NO

53. How old are you?

- ¹ 15 - 20 ² 21 - 25 ³ 26 - 30
- ⁴ 31 - 35 ⁵ 36 - 40 ⁶ over 40

54. After leaving secondary school did you complete any formal qualifications?

¹ YES ² NO

If YES, please say which:

.....

Thank you for filling out this survey. I know that mothers with new babies are busy people and I appreciate your making time in your day. Please put your completed survey form into one of the envelopes provided and either put it into the survey return box in the postnatal ward or post it. (You don't need a stamp). It would help me a lot if you could post it within a week of having received it. If you would like to receive a summary of the results of this survey please provide a postal address and send this slip in the separate envelope provided. (Again, you don't need a stamp). I will send you a copy as soon as one has been prepared. I'm looking forward to receiving your responses. All the best for the future.

THANK YOU



**MASSEY
UNIVERSITY**

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New Zealand
Telephone +64-6-350 5194
Facsimile +64-6-350 5661

**FACULTY OF
BUSINESS STUDIES**

DEPARTMENT OF
MANAGEMENT
SYSTEMS

**CONSUMER EVALUATION OF MATERNITY SERVICE
PROVISION IN THE CENTRAL REGION**

Information Sheet for the Survey

Who is the researcher?

Joy Christison, Ph.D. student, Massey University.

Where can she be contacted?

At home: 15 Union Street or
Palmerston North

Management Systems
Massey University
Private Bag 11 222
Palmerston North

phone: (06) 356 9790

phone: (06) 356 9099 x 5568

Who are the researcher's supervisors?

Prof. Tony Vitalis
Management Systems
Massey University
Private Bag 11 222
Palmerston North

Nicola North
Management Systems
Massey University
Private Bag 11 222
Palmerston North

phone: (06) 350 4388

phone: (06) 350 4378

What is the study about?

This study is concerned with what mothers think about maternity services in the Central Region. Mothers' opinions are being asked for in two ways; a survey and face to face interviews. The first survey and set of interviews were conducted in May/June 1995 and the second survey and set of interviews are being conducted in 1997.

It is your choice whether or not you fill in this survey and your health care will not be affected if you choose not to. If you object to any particular question, just miss it out.

If you have any concerns about ethical aspects of this study you can contact the Manawatu-Wanganui Ethics Committee, PO Box 5203, Palmerston North, telephone/fax (06) 356 7773 or the Wellington Ethics Committee, Wellington Hospital, phone 3855-999 ext. 5185.

WHAT WOMEN HAVE TO SAY ABOUT MATERNITY SERVICES



Kia ora, kia orana, talofa lava, malo e lelei, taloha ni, fakalofa lahi atu, ni sa bula, namaste, hello -

My name is Joy Christison and I have two children, aged 13 and 5. I'm interested in finding out what women in the Central region think about the maternity care they have received. This survey is part of a PhD project at Massey University and is funded by the Central Regional Health Authority. You have been given this survey form because you had a baby in the Central region in the May/June survey period for this year. If you fill out this survey you will be helping to advise the Central Regional Health Authority and local providers on how to improve maternity services in our region.

Of course you can choose not to fill out this form, but I hope you will take this opportunity to have your say. If you object to, or don't understand any question, just miss it out. Don't write your name anywhere on this survey form. Your survey form will not be read by anyone other than myself or my research supervisors.

SECTION 1

Please tick one or more boxes as appropriate

1. Was this the first time you have given birth?

¹ YES ² NO

2. Where did you plan to have this baby?

¹ In hospital
² At home
³ Other

3. Where did you have this baby?

¹ In hospital (please give name of hospital)

² At home
³ Other

4. Was the birth of your baby:

¹ Straightforward vaginal
² With forceps
³ With ventouse (vacuum)
⁴ By Caesarean section
⁵ Not sure

5. When you first found you were pregnant, which of these choices did you know about?

¹ Receiving most of your care from a GP. (A GP is a General Practitioner, or family doctor)
² Receiving most of your care from a midwife
³ Shared care between a GP and a midwife
⁴ Shared care between a midwife and a specialist
⁵ Receiving most of your care from a specialist
⁶ Receiving care from a hospital team
⁷ All of the above
⁸ Didn't know I had any choice

6. Did you get more information about your choices at any stage during your pregnancy?

¹ YES ² NO

If you answered YES to Q.6, where or who did you get this information from?

7. Did the first health professional you saw let you know that you could choose other health professionals to provide your maternity care? (By health professional I mean a midwife or doctor or nurse or specialist).

¹ YES ² NO

8. Did you feel that you understood your options for maternity care at the time that you chose your Lead Maternity Carer (LMC)?

¹ YES ² NO

9. Did one or more of your health professionals discuss a care plan with you at any stage during your pregnancy? (A care plan is a plan of the kind of care that will best suit your needs during pregnancy, birth and afterwards).

¹ YES ² NO

If YES, was the care plan written down?

¹ YES ² NO

If YES, did you keep a copy?

¹ YES ² NO

10. About how many times did you see a health professional during your pregnancy?

- 0-5 6-10 11-15
- 16-20 More than 20

11. Did you see one health professional as having overall responsibility for your maternity care?

- YES NO

If YES, which one?

12. Who provided care for you and your baby during your pregnancy?

- Own midwife
- Own GP
- A GP other than my usual one
- Nurse(s)
- Hospital doctor
- Hospital midwife(s)
- Hospital specialist
- Private specialist

Other (please specify):

13. Who provided care for you and your baby during labour and birth?

- Own midwife
- Own GP
- A GP other than my usual one
- Nurse(s)
- Hospital doctor
- Hospital midwife(s)
- Hospital specialist
- Private specialist

Other (please specify):

14. Who provided care for you and your baby after the baby was born?

- Own midwife
- Own GP
- A GP other than my usual one
- Nurse(s)
- Hospital doctor
- Hospital midwife(s)
- Hospital specialist
- Private specialist

Other (please specify):

SECTION 2

For this section please indicate how much you agree or disagree with the following statements by circling one of the numbers. Choose your number for each statement using the scale below. If a question does not apply to you, circle the 0 in the "does not apply" column.

strongly disagree disagree neither agree nor disagree agree strongly agree does not apply
 1 2 3 4 5 0

Please circle one number for each question

PREGNANCY

	<i>strongly disagree</i>	<i>strongly agree</i>	<i>does not apply</i>
	1	2	3
15. The care I received during my pregnancy suited my individual needs	1	2	3
16. I had the right amount of visits with a health professional	1	2	3
17. I think I had more visits with a health professional than I needed	1	2	3
18. I think I needed more visits with a health professional than I got	1	2	3
19. It was easy to ask my GP questions about my pregnancy	1	2	3
20. It was easy to ask my midwife questions about my pregnancy	1	2	3
21. It was easy to ask my specialist questions about my pregnancy	1	2	3
22. I got good information about different options for labour and birth	1	2	3
23. I was encouraged to plan what I wanted for labour and birth	1	2	3

Any other comments about this section:

	<i>strongly disagree</i>				<i>strongly agree</i>	<i>does not apply</i>
LABOUR AND BIRTH						
24. I felt I was involved with decisions that were made about my care while I was in labour	1	2	3	4	5	0
25. I felt it was fine to ask questions whenever I wanted to	1	2	3	4	5	0
26. I got good explanations about what was happening	1	2	3	4	5	0
27. My support people/ whanau were made to feel welcome	1	2	3	4	5	0
28. My wishes regarding pain relief were respected	1	2	3	4	5	0
29. I needed more pain relief than I was given	1	2	3	4	5	0
30. I was given more pain relief than I needed	1	2	3	4	5	0
31. I felt there was disagreement between two or more of the health professionals involved in my care	1	2	3	4	5	0
32. I had enough privacy during labour	1	2	3	4	5	0
33. I had enough privacy at the time my baby was born	1	2	3	4	5	0
34. I had confidence in <u>all</u> the health professionals who were providing care for me and my baby	1	2	3	4	5	0
35. I had confidence in <u>at least one</u> of the health professionals who were providing care for me and my baby	1	2	3	4	5	0
36. The care I received during labour and birth suited my individual needs	1	2	3	4	5	0

Any other comments about this section:

.....

AFTER YOUR BABY WAS BORN

37. I was happy with the standard of care my baby received	1	2	3	4	5	0
38. I got helpful advice about coping with the demands of a newborn baby	1	2	3	4	5	0
39. I got good advice about how to look after myself after the birth	1	2	3	4	5	0
40. I felt I got good support from at least one health professional	1	2	3	4	5	0
41. A health professional gave me good information about the emotional ups and downs that can happen after having a baby	1	2	3	4	5	0
42. The care I received after my baby was born suited my individual needs	1	2	3	4	5	0
43. Before your baby was born how had you planned to feed your baby? 1 <input type="checkbox"/> breastfeed 2 <input type="checkbox"/> bottle feed 3 <input type="checkbox"/> both						
44. I got conflicting advice about feeding from different health professionals	1	2	3	4	5	0
45. I got helpful advice about feeding from a health professional	1	2	3	4	5	0
46. If you got helpful advice about feeding from a health professional who did you get it from? 1 <input type="checkbox"/> Own midwife 2 <input type="checkbox"/> Hospital midwife 3 <input type="checkbox"/> Hospital nurse 4 <input type="checkbox"/> GP 5 <input type="checkbox"/> Other (please say who):						
47. Did a health professional give a bottle or formula to your baby?	1 <input type="checkbox"/> YES					2 <input type="checkbox"/> NO
48. If YES, did they check with you first if this was OK?	1 <input type="checkbox"/> YES					2 <input type="checkbox"/> NO

Any other comments about this section:

.....

SECTION 3

49. Was there ever a time when you felt a health professional was too busy to attend to your needs?

¹ YES ² NO

If YES, please explain:

.....

50. If you were to have another baby, would you do things differently next time? ¹ YES ² NO

If YES, please explain:

.....

Are there any other comments you would like to make? (Please continue on the extra page if you need to).

.....

SECTION 4

I'm asking the questions in this last section so that I will know if the survey responses include the views of a broad range of women and so that I can identify preferences for different types of care.

51. Please tick which ethnic group/s you feel you belong to?

- ¹ NZ European/ Pakeha
- ² NZ Maori
- ³ Cook Island Maori
- ⁴ Niuean
- ⁵ Tokelauan
- ⁶ Samoan
- ⁷ Tongan
- ⁸ Other Pacific Island
- ⁹ Asian
- ¹⁰ Indian

¹¹ Other (please specify):

52. Were you born in New Zealand?

¹ YES ² NO

53. How old are you?

- ¹ 15 - 20 ² 21 - 25 ³ 26 - 30
- ⁴ 31 - 35 ⁵ 36 - 40 ⁶ over 40

54. After leaving secondary school did you complete any formal qualifications?

¹ YES ² NO

If YES, please say which:

.....

Thank you for filling out this survey. I know that mothers with new babies are busy people and I appreciate your making time in your day. Please put your completed survey form into one of the envelopes provided and either put it into the survey return box in the postnatal ward or post it. (You don't need a stamp). It would help me a lot if you could post it within two weeks of having received it. If you would like to receive a summary of the results of this survey please provide a postal address and send this slip in the separate envelope provided. (Again, you don't need a stamp). I will send you a copy as soon as one has been prepared. I'm looking forward to receiving your responses. All the best for the future.

*** **THANK YOU** ***

Health Funding Authority

Auckland Office

91-95 Mt Eden Road
Mt Eden
Private Bag 92522
Wellesley Street
AUCKLAND
New Zealand
Telephone 09 357 4300
Facsimile 09 357 4301

Survey Information Sheet

WHAT WOMEN HAVE TO SAY ABOUT MATERNITY SERVICES NATIONAL SURVEY 1999

Kia ora, kia orana, talofa lava, malo e lelei, taloha ni, fakalofa lahi atu,
ni sa bula, namaste, hello

This is a national survey designed to find out what women think about the maternity care they have received. It is funded by the Health Funding Authority. If you fill out this survey form you will be helping to advise the Health Funding Authority about current maternity services. A report summarising the responses to this survey will form part of the review of maternity services which is being carried out by the Health Funding Authority and the National Health Committee this year.

We hope you take this opportunity to have your say. **Survey forms need to be returned by May 7.** Thank you for taking the time to do this.

Who is the researcher?

Joy Christison, Maternity Consumer Adviser (Health Funding Authority)

Where can she be contacted?

Health Funding Authority	Phone:	(09) 357 4300
Auckland Office	Fax:	(09) 357 4301
Private Bag 92522	Home phone:	(09) 411 7796
Wellesley St	Freephone:	(Mon – Fri 9.30am – 2.30pm)
Auckland		0800 686 223

Please feel free to contact the researcher if you have any concerns about this study, or if you would like more information about it.

What is the research about?

The research is concerned with what mothers think about the maternity services which are currently provided in New Zealand. A report summarising the responses to this survey will help to inform an evaluation of current maternity services which will be carried out in 1999.

You're invited to take part.

You have been sent this survey form because you had a baby in New Zealand in February 1999. It is your choice whether or not you fill in this survey form and your health care will not be affected if you choose not to. If you object to or don't understand any question, just miss it out. You do not have to answer all the questions.

How was my name and address selected?

The researcher does not know your name and address. Health Benefits Limited (HBL) is the organisation that pays health professionals on behalf of the government for providing maternity care. Staff at Health Benefits Limited arranged for the names and addresses of all women on their records who gave birth in February 1999 to be printed onto envelopes. Envelopes were then filled with survey forms and forwarded directly to the post.

Results

If you would like to receive a summary of the findings of this study, please fill in the address slip and send it in the separate freepost envelope provided. Summaries will be sent out in early June 1999.

Ethical approval

This study has received ethical approval from the **HFA Wellington Ethics Committee**.

If you have any concerns about the study, you may contact: The Wellington Ethics Committee, Wellington Hospital, Telephone 385 5999 ext 5185.

✂.....

WHAT WOMEN HAVE TO SAY ABOUT MATERNITY SERVICES – NATIONAL SURVEY 1999

If you would like to receive a summary of the results of this survey please provide a postal address and send this slip in the separate envelope provided. You will be sent a copy in early June.

.....
.....
.....
.....
.....

SECTION 1

Please tick one or more boxes as appropriate

1. Was this the first time you had given birth?

- YES NO

2. Where did you plan to give birth to this baby?

- In hospital
- At home
- Other

3. Where did you give birth to this baby?

- In hospital (please give name of hospital)

.....

- At home
- Other

4. Was the birth of your baby:

- Straightforward vaginal
- With forceps
- With ventouse (vacuum)
- By Caesarean section

5. When you first found you were pregnant, did you know that you needed to choose and register with a lead maternity carer (LMC)?

- YES NO

6. If you answered NO to Q.5, did someone explain this to you in early pregnancy?

- YES NO

If you answered YES to Q.6, who did you get this information from?

- GP
- Midwife
- Specialist
- Family Planning Clinic
- Family or friends
- Other (please specify)

.....

7. Was it difficult for you to find a suitable lead maternity carer to provide care for you?

- YES NO

If you answered YES to Q. 7, please explain why:

.....

8. When you register with a lead maternity carer (LMC) you sign a registration form to confirm that you have chosen this health professional to be responsible for co-ordinating all of your maternity care.

Who did you first register with as your lead maternity carer?

- Independent midwife
- Own GP
- A GP other than my usual one
- Hospital midwife/midwives
- Hospital specialist
- Hospital team
- Private specialist

9. Did you know that you could change your lead maternity carer at any stage during your pregnancy?

- YES NO

10. Did you in fact change your lead maternity carer at any stage during your pregnancy?

- YES NO

If you answered NO, please go to Question 13.

11. What was the reason for changing lead maternity carers?

- My medical condition required a transfer to specialist care
- I moved to a different location
- I wasn't happy with the care I received from my first LMC
- My first LMC stopped providing care
- Other (please specify):

.....

12. If the decision to change lead maternity carers was yours alone, was this decision easily accepted by your first lead maternity carer?

- YES NO

If NO, please explain:

.....

13. Did one or more of your health professionals discuss a care plan with you at any stage during your pregnancy? (A care plan is a plan of the kind of care that will best suit your needs during pregnancy, birth and afterwards).

1 YES 2 NO

If YES, was the care plan written down?

1 YES 2 NO

If YES, did you keep a copy?

1 YES 2 NO

14. About how many times did you see a health professional during your pregnancy?

1 0-5 2 6-10 3 11-15

4 16-20 5 More than 20.

15. Who provided care for you and your baby during your pregnancy?

- 1 Independent midwife
2 Own GP
3 A GP other than my usual one
4 Nurse(s)
5 Hospital doctor
6 Hospital midwife(s)
7 Hospital specialist
8 Private specialist

9 Other (please specify):

16. At the time that you went into labour, who were you registered with as your lead maternity carer?

- 1 Independent midwife
2 Own GP
3 A GP other than my usual one
4 Hospital midwife/midwives
5 Hospital specialist
6 Hospital team
7 Private specialist

17. Who else provided care for you and your baby during labour and birth?

- 1 Independent midwife
2 Own GP
3 A GP other than my usual one
4 Nurse(s)
5 Hospital doctor
6 Hospital midwife(s)
7 Hospital specialist
8 Private specialist

9 Other (please specify)

.....

18. Who provided care for you and your baby after the baby was born?

- 1 Independent midwife
2 Own GP
3 A GP other than my usual one
4 Nurse(s)
5 Hospital doctor
6 Hospital midwife(s)
7 Hospital specialist
8 Private specialist

9 Other (please specify):

.....

19. Were you charged for any of the following services (please say how much):

- 1 Positive pregnancy test \$.....
2 Ultrasound scan(s) \$.....
3 Care from an obstetrician \$.....
4 Care from a GP \$.....
5 Care from a midwife \$.....
6 Other (please specify)

..... \$.....

Any other comments about charges?

.....
.....
.....
.....
.....
.....
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.....
.....
.....

20. How many times did you have to make a call to a cell phone number to contact a health professional about your maternity care?

Number of calls:

21. What was the approximate total cost of these calls?

Approximate total cost: \$

SECTION 2

For this section please indicate how much you agree or disagree with the following statements by circling one of the numbers. Choose your number for each statement using the scale below. If a question does not apply to you, circle the 0 in the "does not apply" column.

strongly disagree 1 disagree 2 neither agree nor disagree 3 agree 4 strongly agree 5 does not apply 0

Please circle one number for each question
strongly disagree strongly agree does not apply

PREGNANCY

- | | | | | | | |
|---|---|---|---|---|---|---|
| 22. The care I received during my pregnancy suited my individual needs | 1 | 2 | 3 | 4 | 5 | 0 |
| 23. I had the right amount of visits with a health professional | 1 | 2 | 3 | 4 | 5 | 0 |
| 24. I think I had more visits with a health professional than I needed | 1 | 2 | 3 | 4 | 5 | 0 |
| 25. I think I needed more visits with a health professional than I got | 1 | 2 | 3 | 4 | 5 | 0 |
| 26. It was easy to ask my GP questions about my pregnancy | 1 | 2 | 3 | 4 | 5 | 0 |
| 27. It was easy to ask my midwife questions about my pregnancy | 1 | 2 | 3 | 4 | 5 | 0 |
| 28. It was easy to ask my specialist questions about my pregnancy | 1 | 2 | 3 | 4 | 5 | 0 |
| 29. I got good information about different options for labour and birth | 1 | 2 | 3 | 4 | 5 | 0 |
| 30. I was encouraged to plan what I wanted for labour and birth | 1 | 2 | 3 | 4 | 5 | 0 |

strongly disagree strongly agree does not apply

LABOUR AND BIRTH

- | | | | | | | |
|--|---|---|---|---|---|---|
| 31. I felt I was involved with decisions that were made about my care while I was in labour | 1 | 2 | 3 | 4 | 5 | 0 |
| 32. I felt it was fine to ask questions whenever I wanted to | 1 | 2 | 3 | 4 | 5 | 0 |
| 33. I got good explanations about what was happening | 1 | 2 | 3 | 4 | 5 | 0 |
| 34. My support people/ whanau were made to feel welcome | 1 | 2 | 3 | 4 | 5 | 0 |
| 35. My wishes regarding pain relief were respected | 1 | 2 | 3 | 4 | 5 | 0 |
| 36. I needed more pain relief than I was given | 1 | 2 | 3 | 4 | 5 | 0 |
| 37. I was given more pain relief than I needed | 1 | 2 | 3 | 4 | 5 | 0 |
| 38. I felt there was disagreement between two or more of the health professionals involved in my care | 1 | 2 | 3 | 4 | 5 | 0 |
| 39. I had enough privacy during labour | 1 | 2 | 3 | 4 | 5 | 0 |
| 40. I had enough privacy at the time my baby was born | 1 | 2 | 3 | 4 | 5 | 0 |
| 41. I had confidence in <u>all</u> the health professionals who were providing care for me and my baby | 1 | 2 | 3 | 4 | 5 | 0 |
| 42. I had confidence in <u>at least one</u> of the health professionals who were providing care for me and my baby | 1 | 2 | 3 | 4 | 5 | 0 |
| 43. The care I received during labour and birth suited my individual needs | 1 | 2 | 3 | 4 | 5 | 0 |

Please answer the following three questions only if your lead maternity carer was not a specialist, but a specialist was called in during your labour and birth

- | | | | | | | |
|---|---|---|---|---|---|---|
| 44. I feel the specialist was called at the right time | 1 | 2 | 3 | 4 | 5 | 0 |
| 45. There was good communication between my lead maternity carer and the specialist | 1 | 2 | 3 | 4 | 5 | 0 |

46. If care was handed over to the specialist, did the handover go smoothly: YES NO

If NO, please explain why not:

.....

Please circle one number for each question

	strongly disagree	1	2	3	4	5	strongly agree	does not apply
--	----------------------	---	---	---	---	---	-------------------	----------------------

AFTER YOUR BABY WAS BORN

47. I was happy with the standard of care my baby received 1 2 3 4 5 0

48. I got helpful advice about coping with the demands of a newborn baby 1 2 3 4 5 0

49. I got good advice about how to look after myself after the birth 1 2 3 4 5 0

50. I felt I got good support from at least one health professional 1 2 3 4 5 0

51. A health professional gave me good information about the emotional ups and downs that can happen after having a baby 1 2 3 4 5 0

52. The care I received after my baby was born suited my individual needs 1 2 3 4 5 0

53. Before your baby was born how had you planned to feed your baby?
 breastfeed bottle feed both

54. I got conflicting advice about feeding from different health professionals 1 2 3 4 5 0

55. I got helpful advice about feeding from a health professional 1 2 3 4 5 0

56. If you got helpful advice about feeding from a health professional who did you get it from?

- Own midwife
- Hospital midwife
- Hospital nurse
- GP
- Other (please say who):

57. My lead maternity carer explained clearly the kind of breastfeeding help and advice that would be available for me 1 2 3 4 5 0

58. It was clear to me what sort of breastfeeding help and advice I could expect from my lead maternity carer 1 2 3 4 5 0

59. It was clear to me what sort of breastfeeding help and advice I could expect from hospital staff 1 2 3 4 5 0

60. Did a health professional give a bottle or formula to your baby? YES NO

61. If YES, did they check with you first if this was OK? YES NO

62. If your baby was born in a hospital or maternity unit, how long after the birth did you return home?

63. I felt pressured to leave before I was ready 1 2 3 4 5 0

64. I felt I was welcome to stay for as long as I needed to 1 2 3 4 5 0

65. During your postnatal stay, was there ever a time when you felt a health professional was too busy to attend to your needs?

YES NO

If YES, please explain:

.....

66. How many times did a midwife visit you at your home after your baby was born?

67. How many weeks old was your baby when a midwife visited you at home for the last time?

A provider of Well Child health services will provide a scheduled programme of helping you to oversee your baby's growth and development, beginning four to six weeks after birth. These are preventative services and they are different from the medical care you get from your GP when your child is sick. The service includes checks and immunisations for your children and information and support for their caregiver. Some examples of Well Child providers are: Plunket, Public Health Nurses, General practitioners, Practice Nurses, Kaitiaki and Kaiawhina, Whanau Ora, Tipu Ora.

68. Did your lead maternity carer talk to you about arrangements for a Well Child provider? ¹ YES ² NO

69. At the time that you had your last maternity visit with your lead maternity carer, did you know who was going to be providing your Well Child programme of visits? ¹ YES ² NO

70. What was good about the way maternity care was provided for you? What would you like to see stay the same?

.....

71. What was not good about the way maternity care was provided for you? What would you like to see change?

.....

SECTION 3

I'm asking the questions in this last section so that I will know if the survey responses include the views of a broad range of women.

72. Please tick as many boxes as you need to show which ethnic groups you belong to:

- ¹ NZ Maori
² NZ European or Pakeha
³ Other European
⁴ Samoan
⁵ Cook Island Maori
⁶ Tongan
⁷ Niuean
⁸ Chinese
⁹ Indian
¹⁰ Other (please specify):

73. Were you born in New Zealand?

- ¹ YES ² NO

74. Do you live:

- ¹ In or near a city or major provincial town
² In a rural location

75. How old are you?

- ¹ under 15 ² 15 - 19 ³ 20 - 24
⁴ 25 - 29 ⁵ 30 - 34 ⁶ 35 - 39
⁷ 40+

76. Which of these qualifications have you completed?

- ¹ School Certificate
² Sixth Form Certificate
³ University Entrance or Bursary
⁴ A tertiary (Polytechnic, Teachers College, University) qualification
⁵ Left school without any qualifications

77. What is your annual household income?

- ¹ under \$20,000 ² \$20,000 - \$29,999
³ \$30,000 - \$39,999 ⁴ \$40,000 - \$49,999
⁵ \$50,000 - \$59,999 ⁶ over \$60,000

Appendix 5: Likert Scale Results

Appendix 5A: 1995 Central Region survey

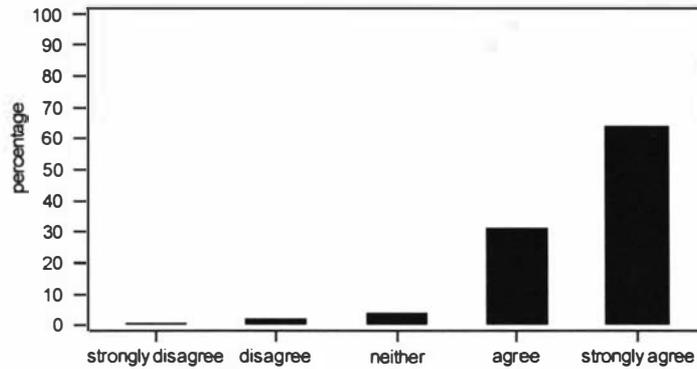
Appendix 5B: 1997 Central Region survey

Appendix 5C: 1999 National survey

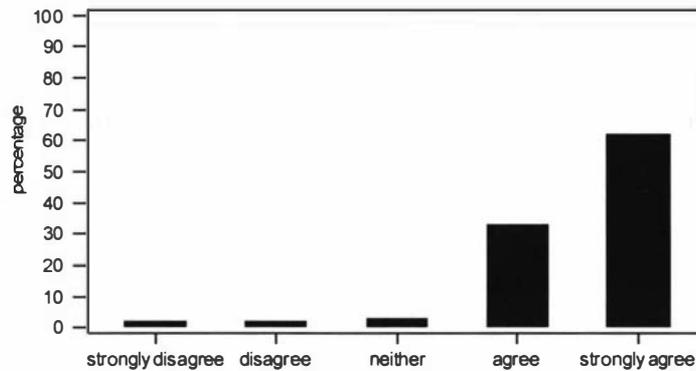
Appendix 5A: Likert Scale Results - 1995 Survey

Section A.5A.1. Pregnancy

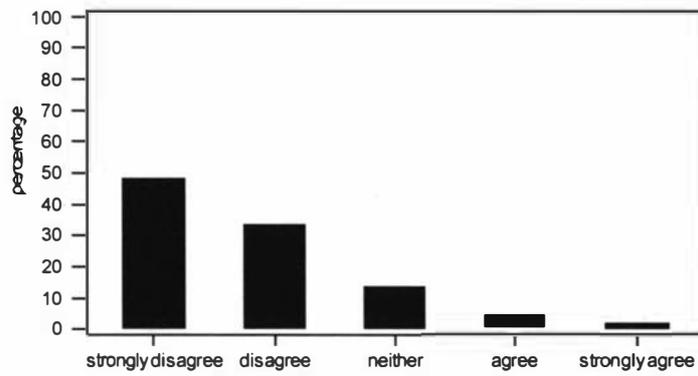
Q15. The care I received during my pregnancy suited my individual needs



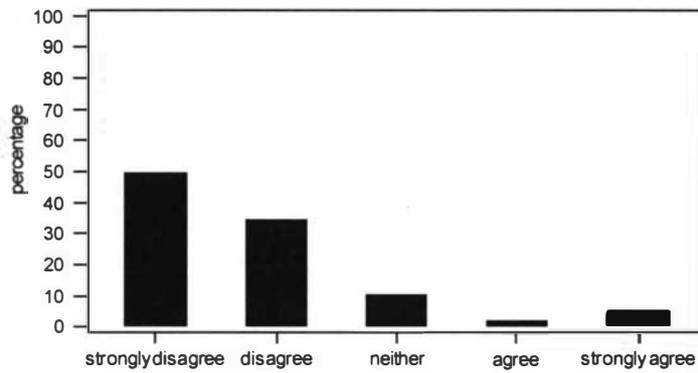
Q16. I had the right amount of visits with a health professional



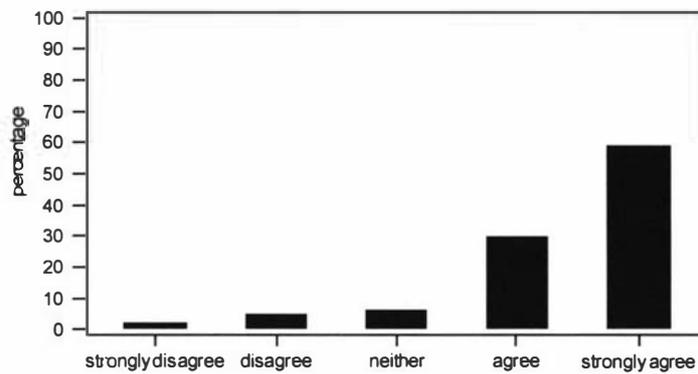
Q17. I think I had more visits with a health professional than I needed



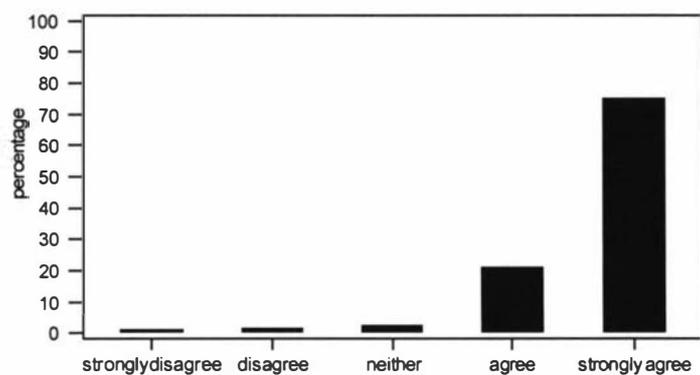
Q18. I think I needed more visits with a health professional than I got



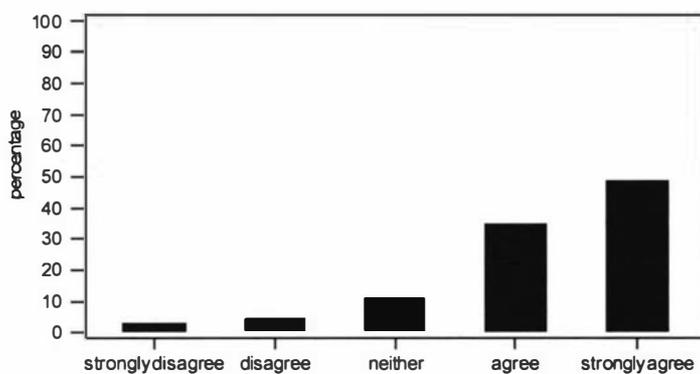
Q19. It was easy to ask my GP questions about my pregnancy



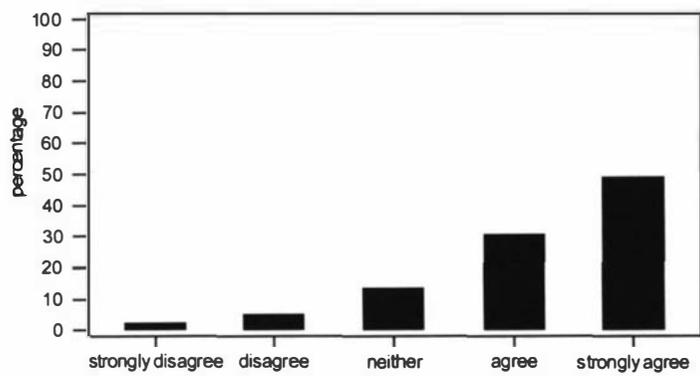
Q20. It was easy to ask my midwife questions about my pregnancy



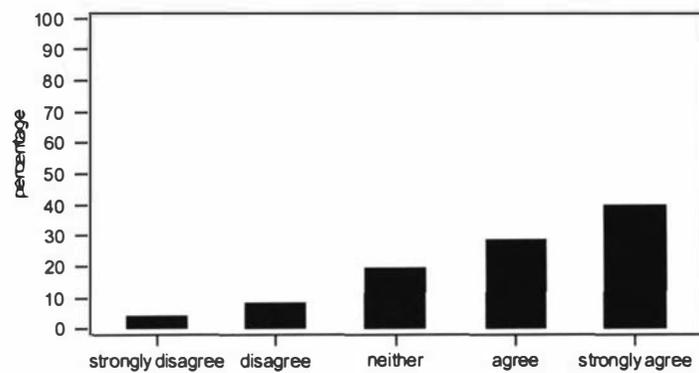
Q21. It was easy to ask my specialist questions about my pregnancy



Q22. I got good information about different options for labour and birth

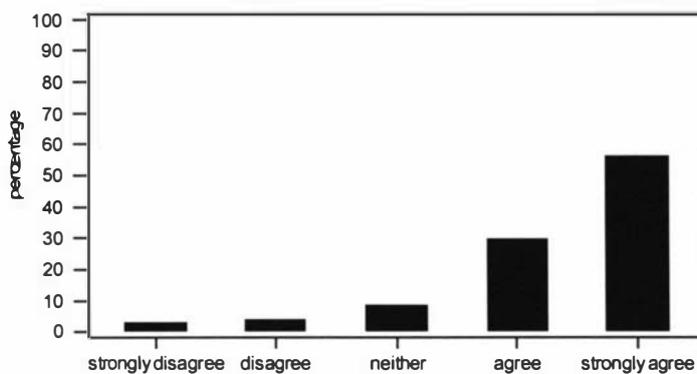


Q23. I was encouraged to plan what I wanted for labour and birth

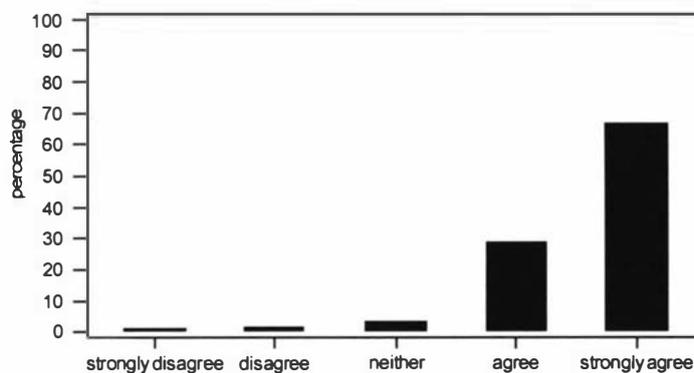


Section A.5A.2. Labour and Birth

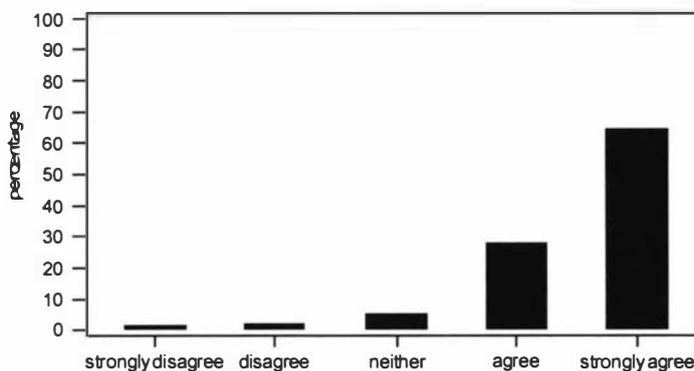
Q24. I felt I was involved with decisions that were made about my care while I was in labour



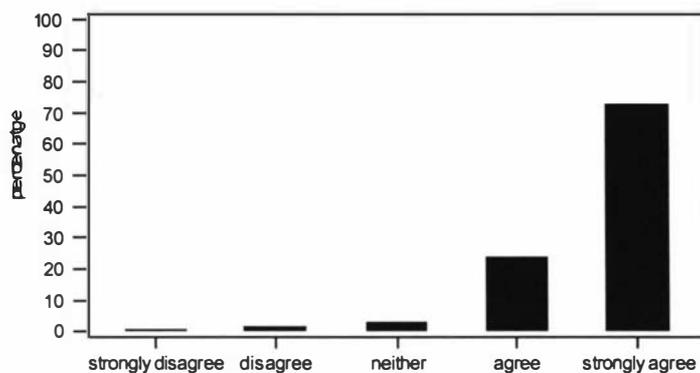
Q25. I felt it was fine to ask questions whenever I wanted to



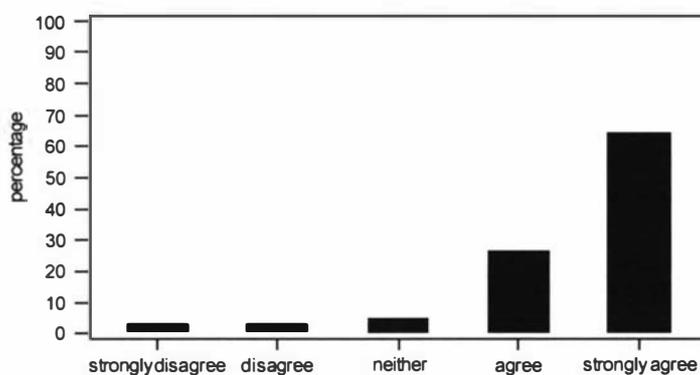
Q26. I got good explanations about what was happening



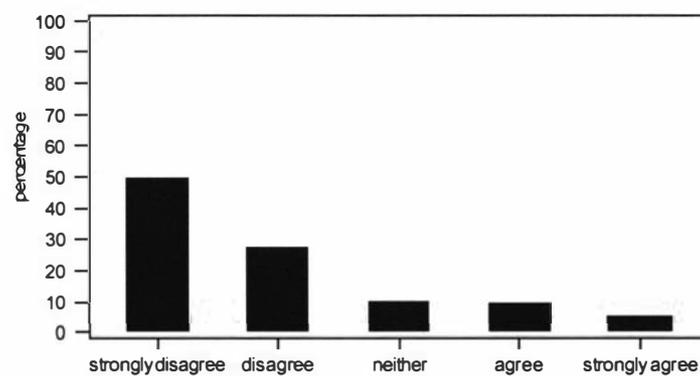
Q27. My support people/whanau were made to feel welcome



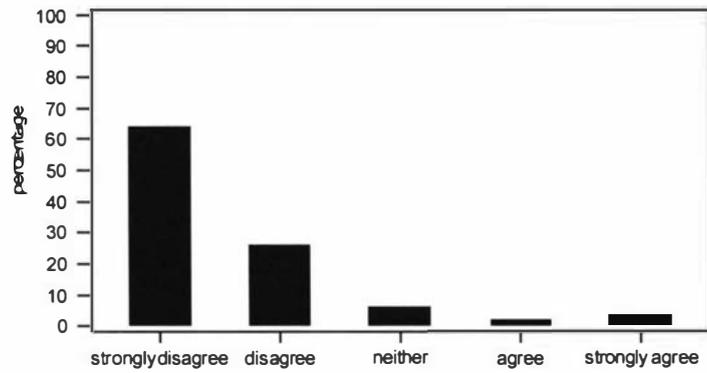
Q28. My wishes regarding pain relief were respected



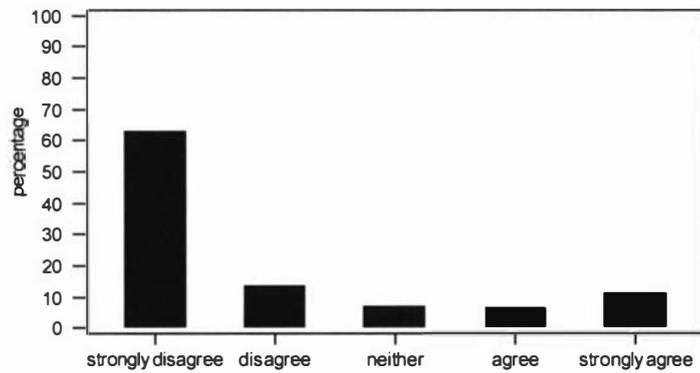
Q29. I needed more pain relief than I was given



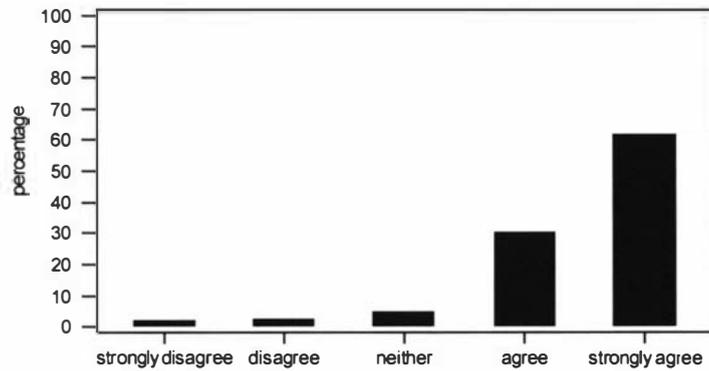
Q30. I was given more pain relief than I needed



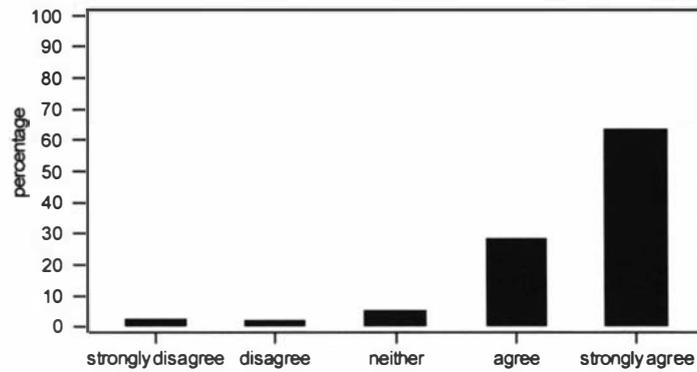
Q31. I felt there was disagreement between two or more of the health professionals involved in my care



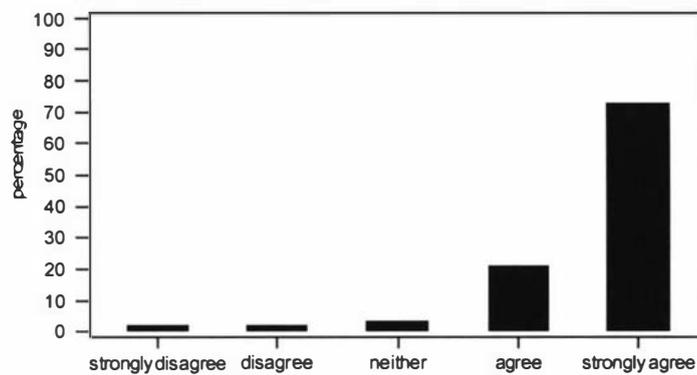
Q32. I had enough privacy during labour



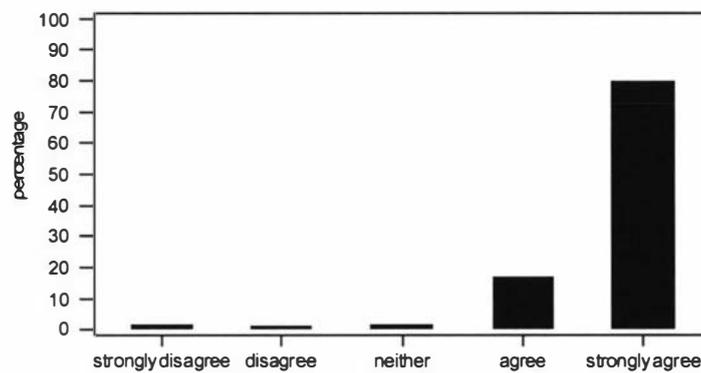
Q33. I had enough privacy at the time my baby was born

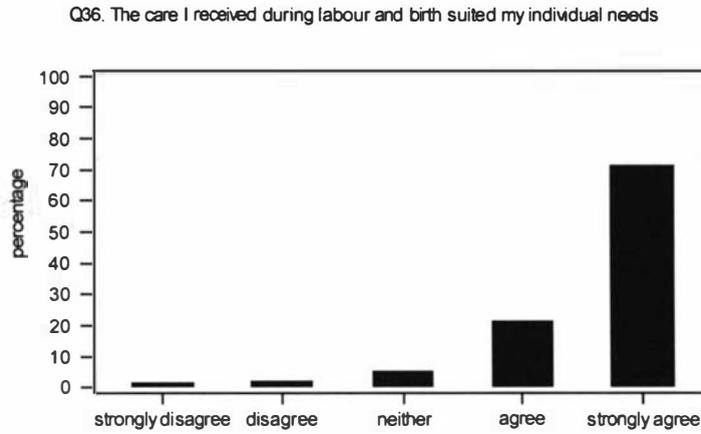


Q34. I had confidence in all the health professionals who were providing care for me and my baby

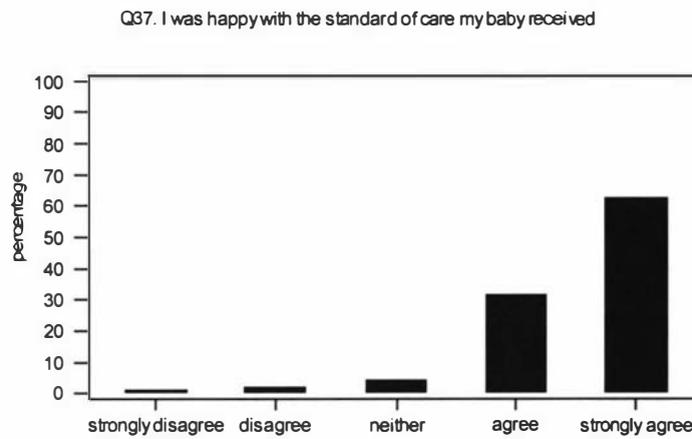


Q35. I had confidence in at least one of the health professionals who were providing care for me and my baby

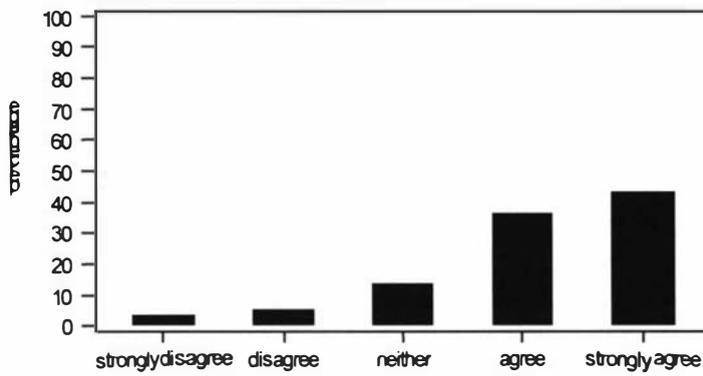




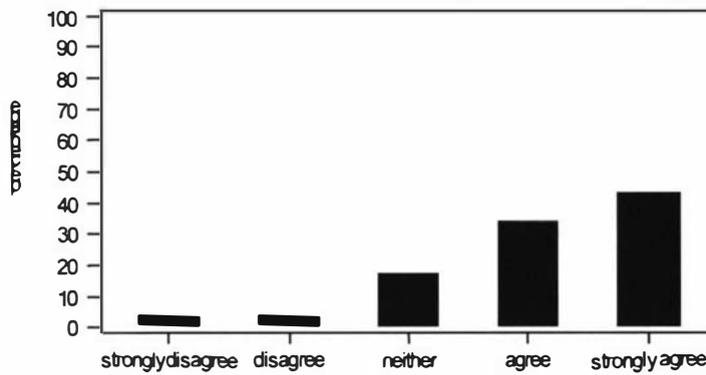
Section A.5A.3. After the Birth



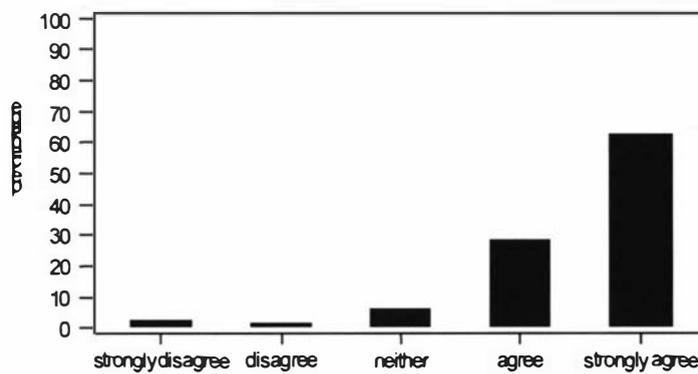
Q38. I got helpful advice about coping with the demands of a newborn baby



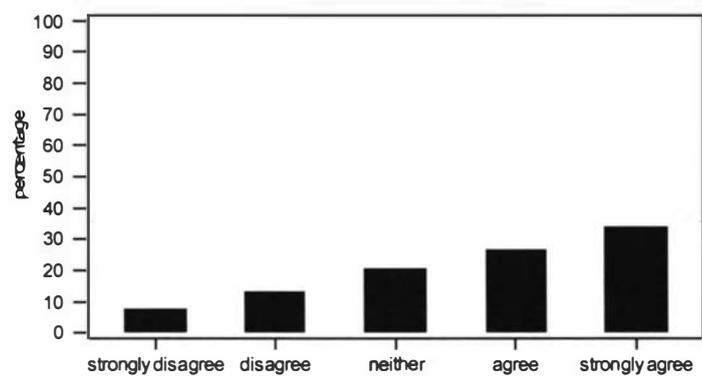
Q39. I got good advice about how to look after myself after the birth



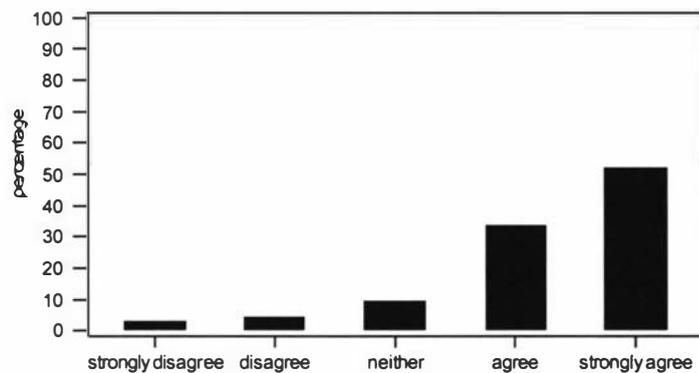
Q40. I felt I got good support from at least one health professional



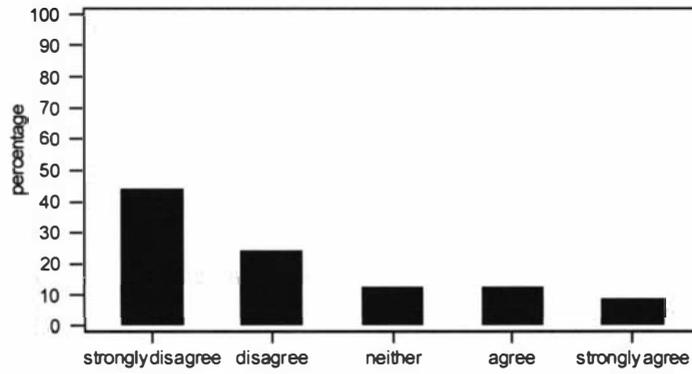
Q41. A health professional gave me good information about the emotional ups and downs that can happen after having a baby



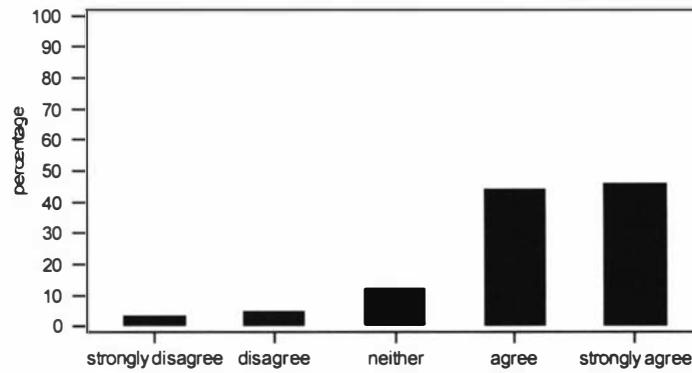
Q42. The care I received after my baby was born suited my individual needs



Q44. I got conflicting advice about feeding from different health professionals



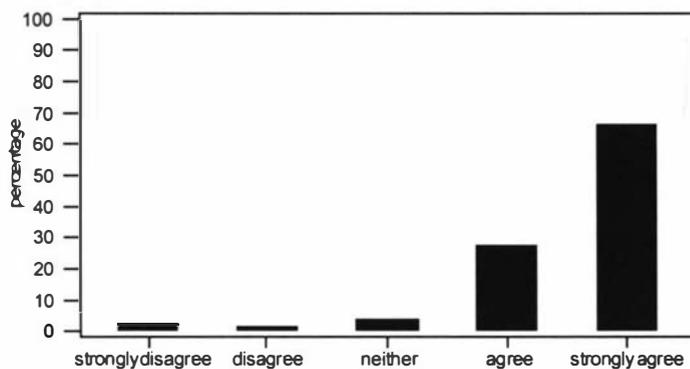
Q45. I got helpful advice about feeding from a health professional



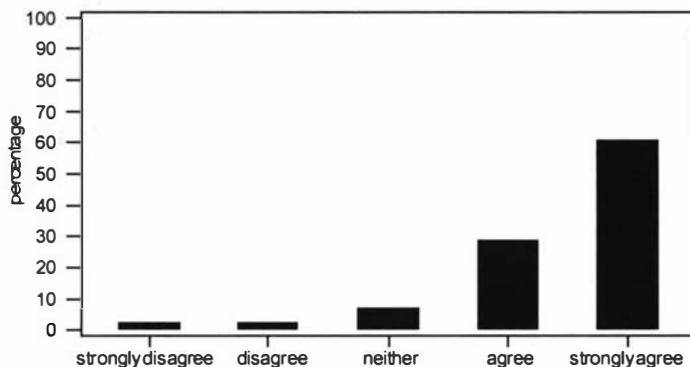
Appendix 5B: Likert Scale Results - 1997 Survey

Section A.5B.1 Pregnancy

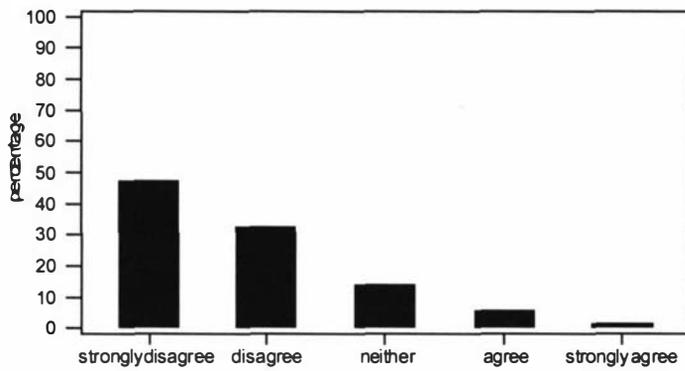
Q15. The care I received during my pregnancy suited my individual needs



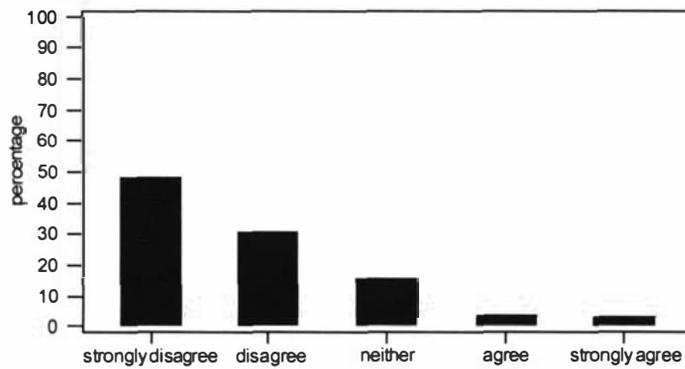
Q16. I had the right amount of visits with a health professional



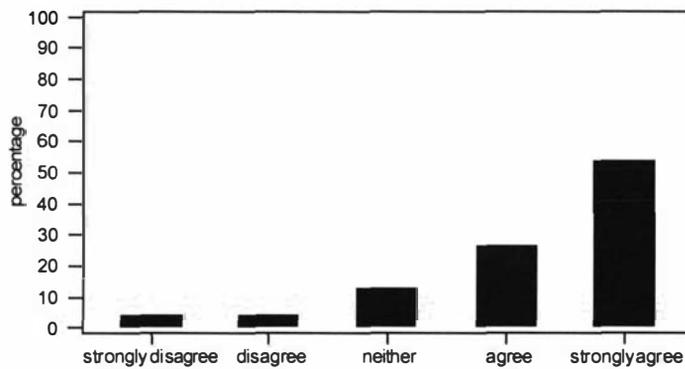
Q17. I think I had more visits with a health professional than I needed

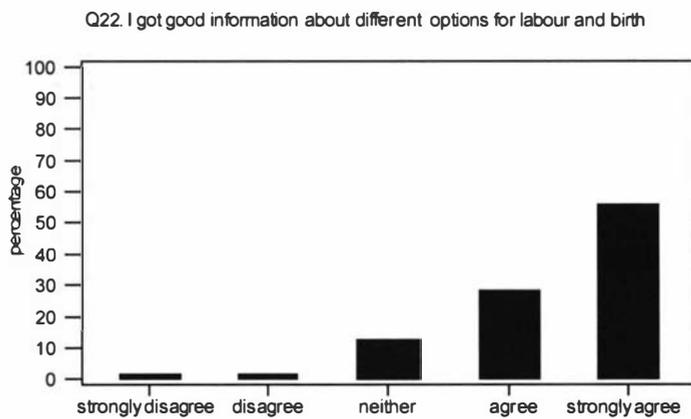
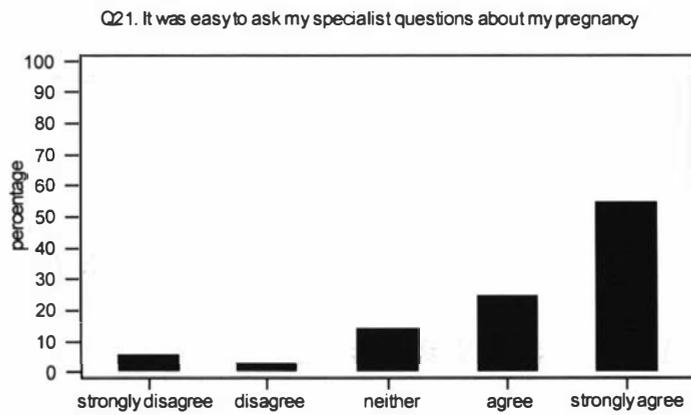
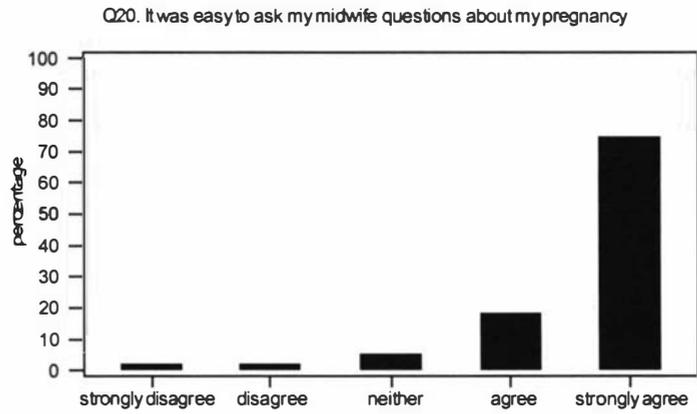


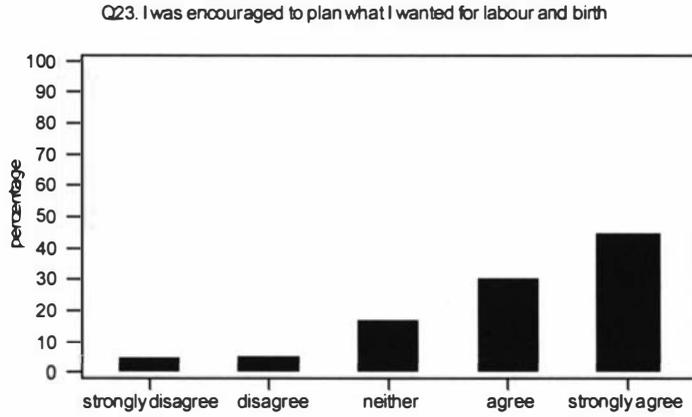
Q18. I think I needed more visits with a health professional than I got



Q19. It was easy to ask my GP questions about my pregnancy

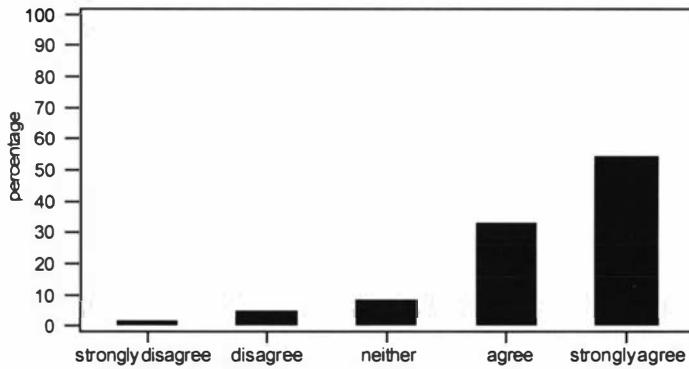




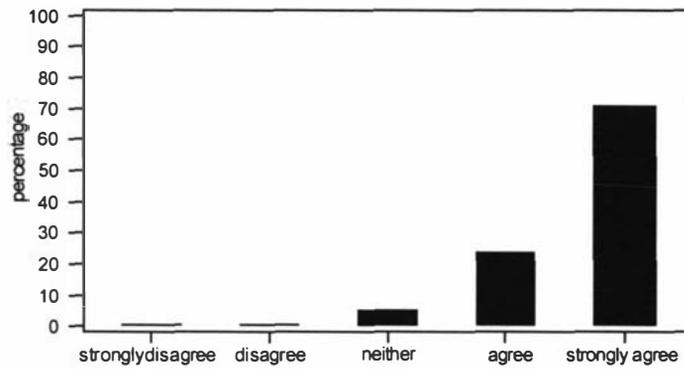


Section A.5B.2 Labour and Birth

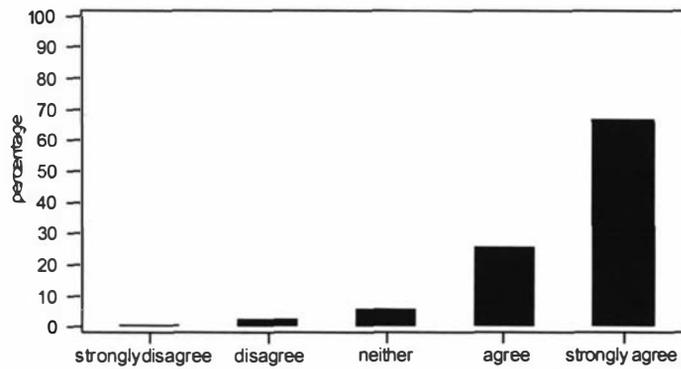
Q24. I felt I was involved with decisions that were made about my care while I was in labour



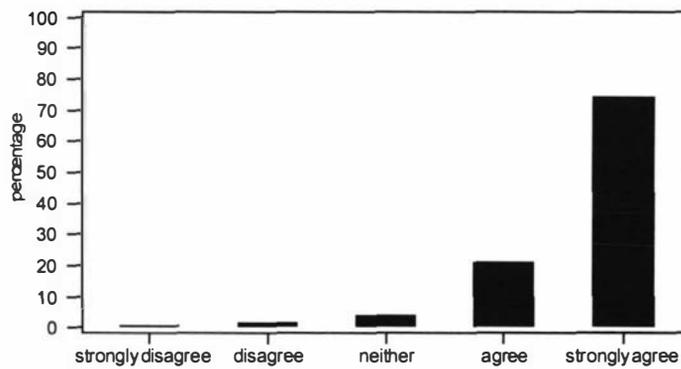
Q25. I felt it was fine to ask questions whenever I wanted to

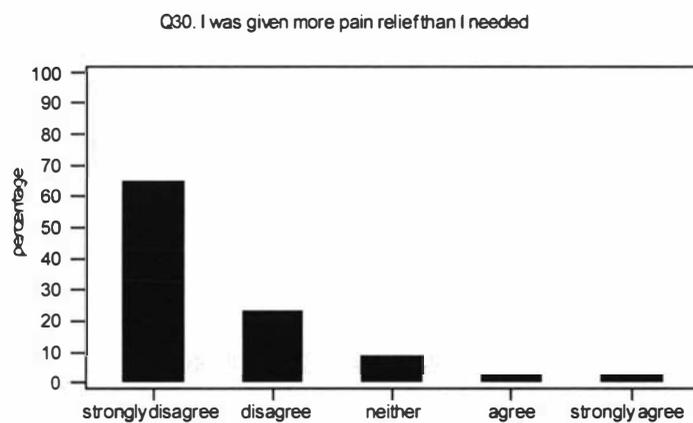
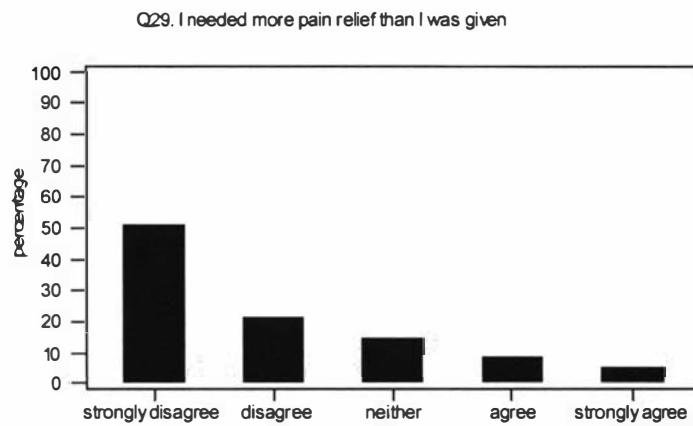
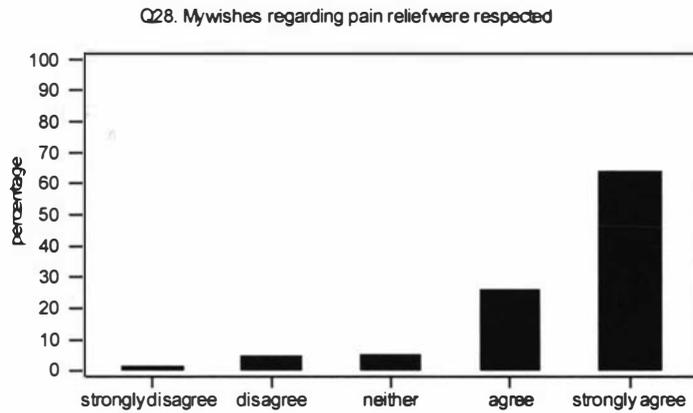


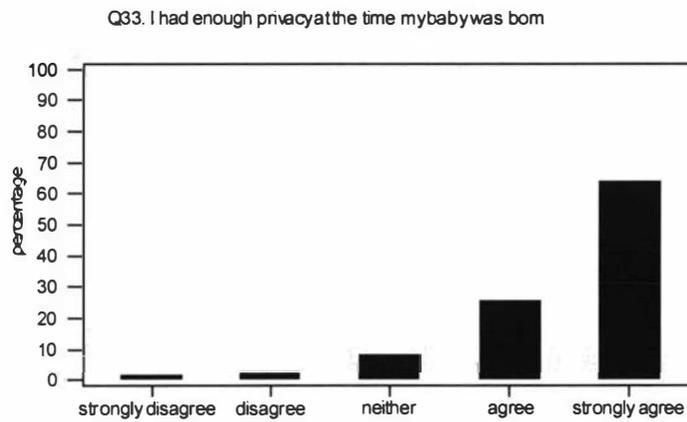
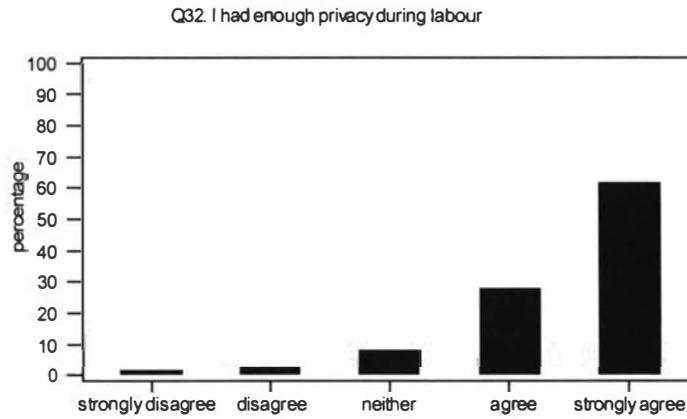
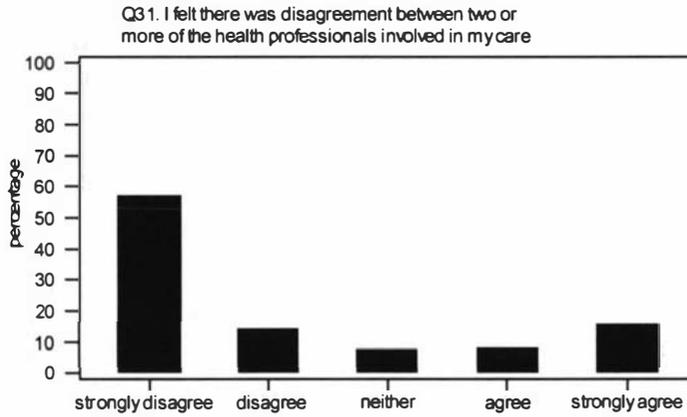
Q26. I got good explanations about what was happening

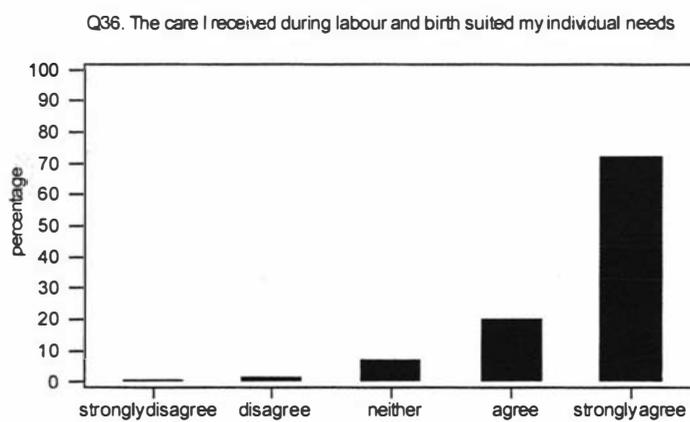
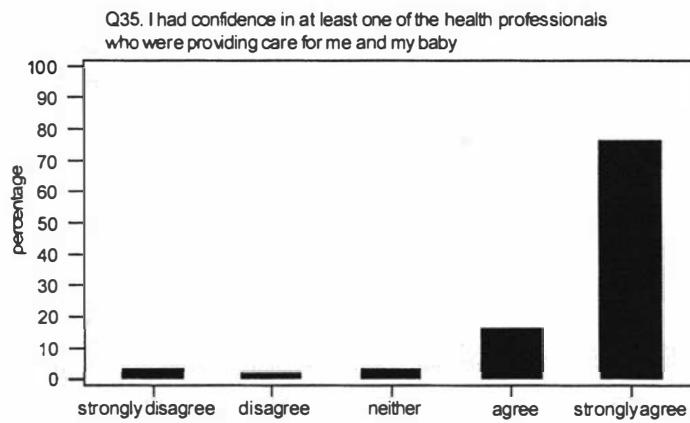
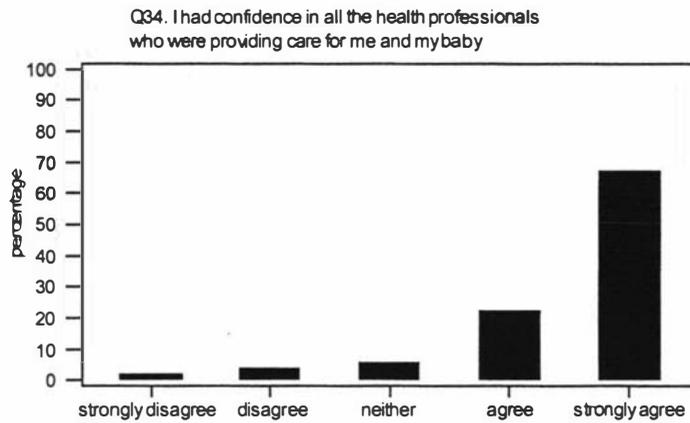


Q27. My support people/whanau were made to feel welcome



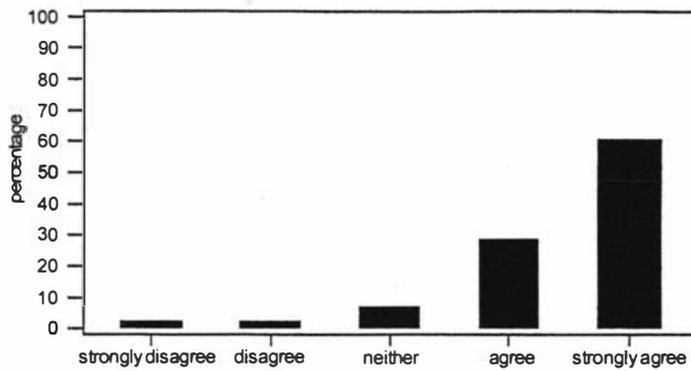




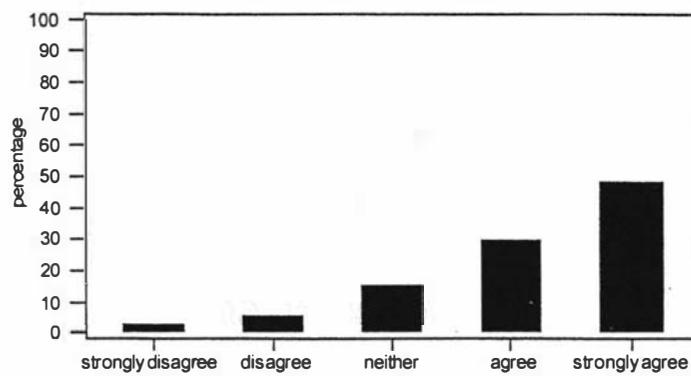


Section A.5B.3 After the Birth

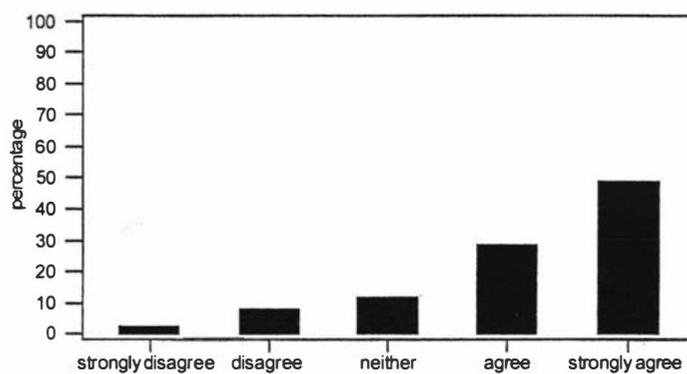
Q37. I was happy with the standard of care my baby received

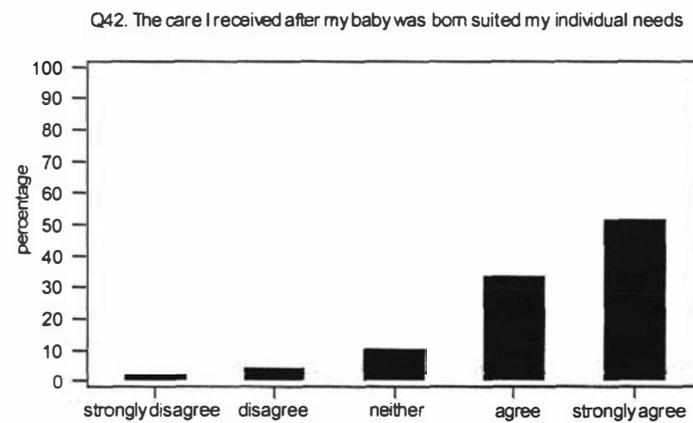
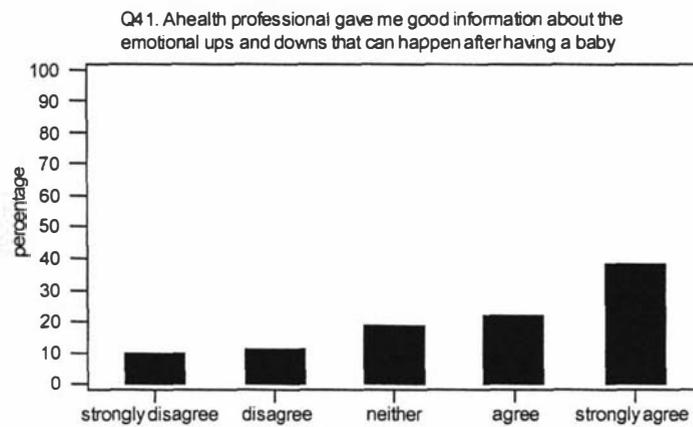
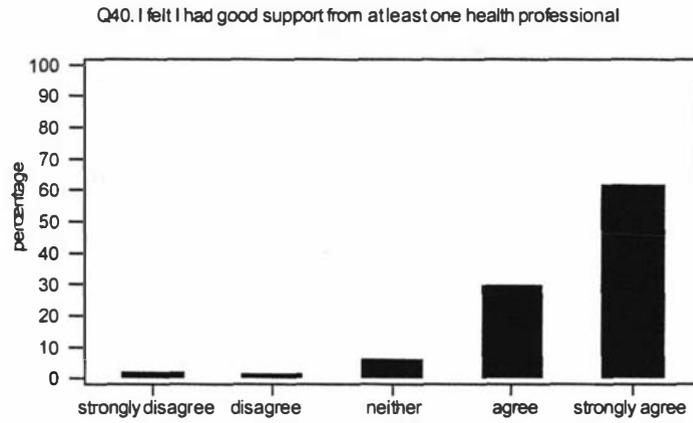


Q38. I got helpful advice about coping with the demands of a newborn baby

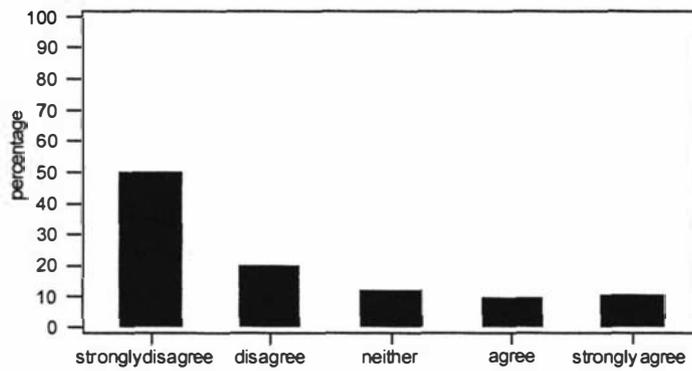


Q39. I got good advice about how to look after myself after the birth

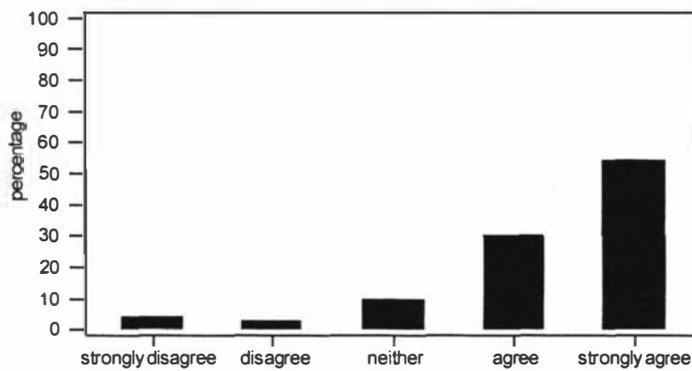




Q44. I got conflicting advice about breastfeeding from different health professionals



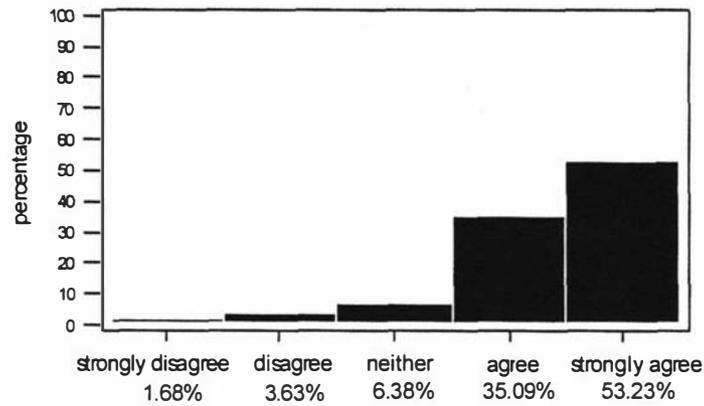
Q45. I got helpful advice about feeding from a health professional



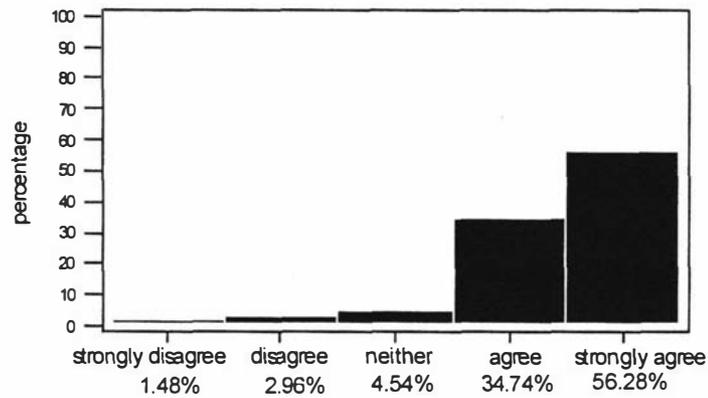
Appendix 5C: Likert Scale Results – 1999 National Survey

Section A.5C.1 Pregnancy

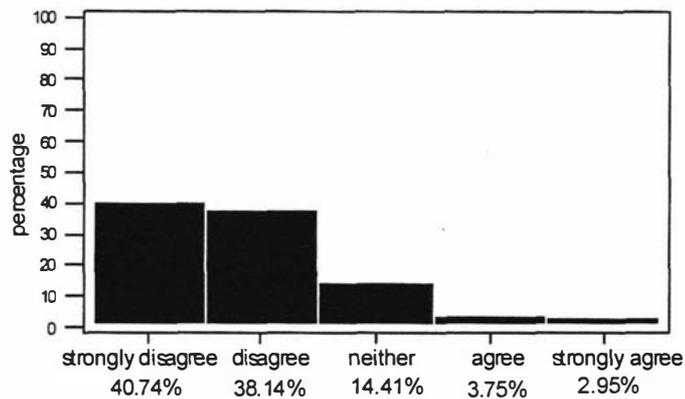
Q23 I had the right amount of visits with a health professional



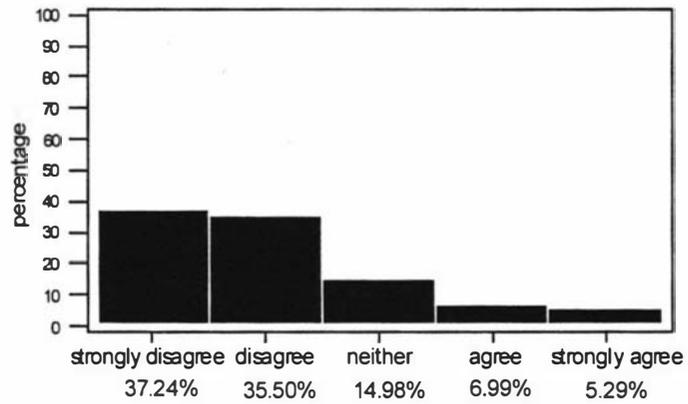
Q22 The care I received during my pregnancy suited my individual needs



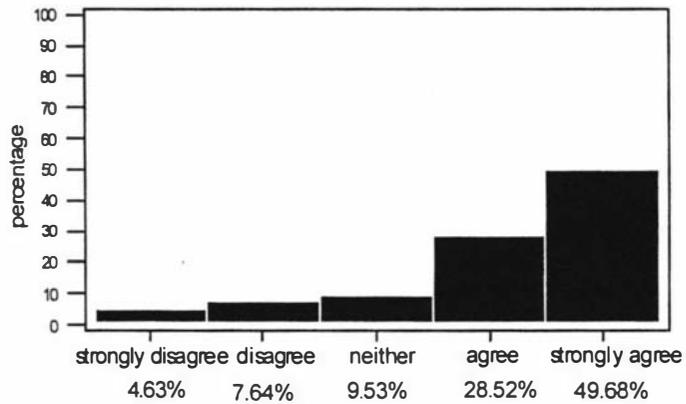
Q24 I think I had more visits with a health professional than I needed



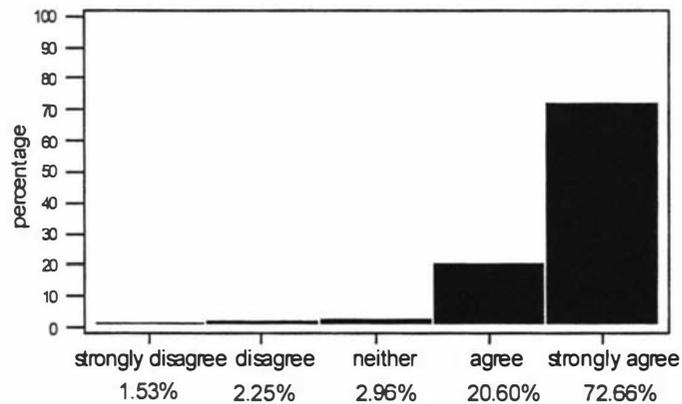
Q25 I think I needed more visits with a health professional than I got



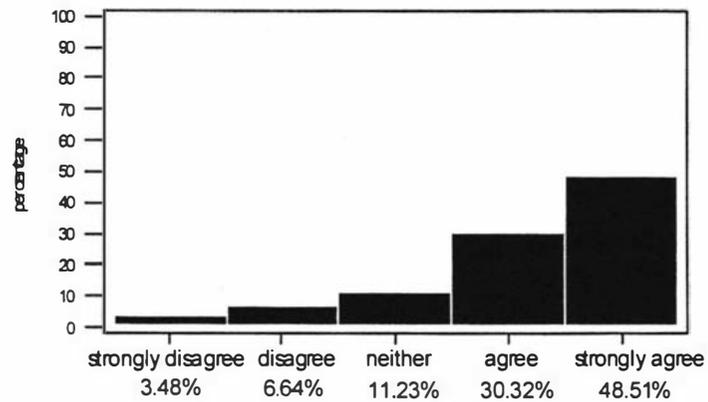
Q26 It was easy to ask my GP questions about my pregnancy



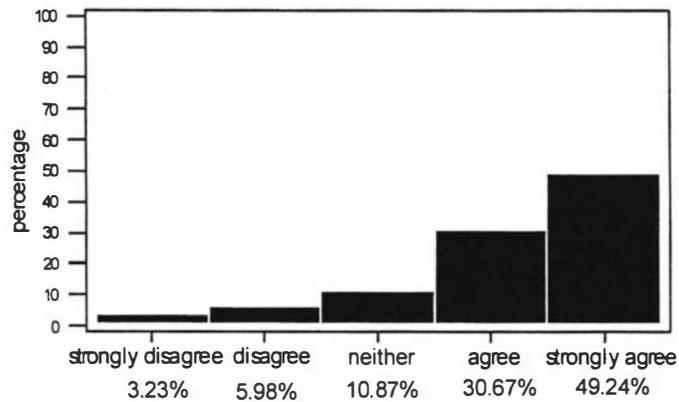
Q27 It was easy to ask my midwife questions about my pregnancy



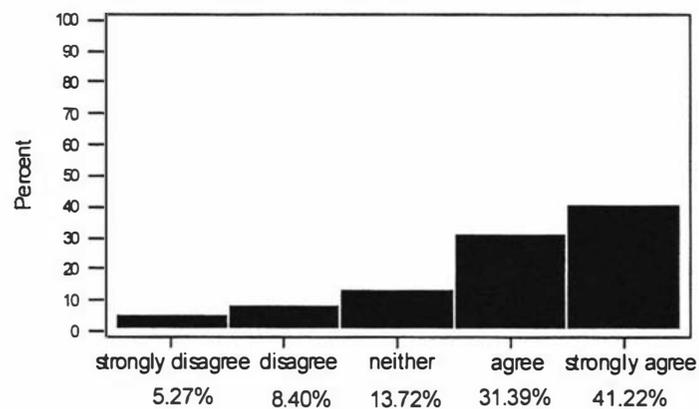
Q28 It was easy to ask my specialist questions about my pregnancy



Q29 I got good information about different options for labour and birth

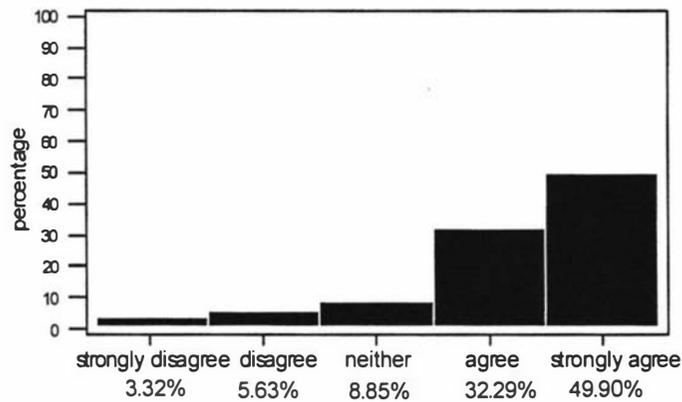


Q30 I was encouraged to plan what I wanted for labour and birth

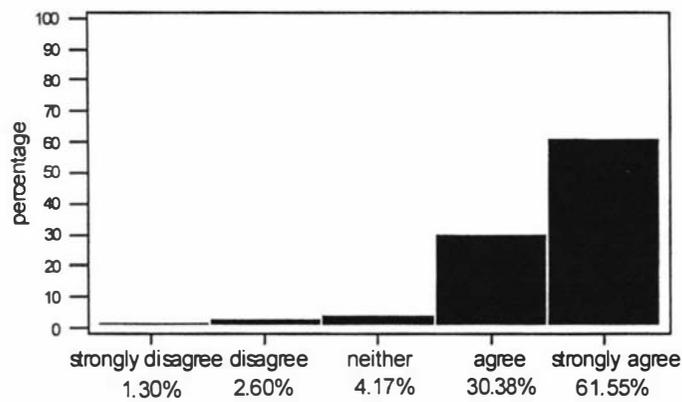


Section A.5C.2 Labour and Birth

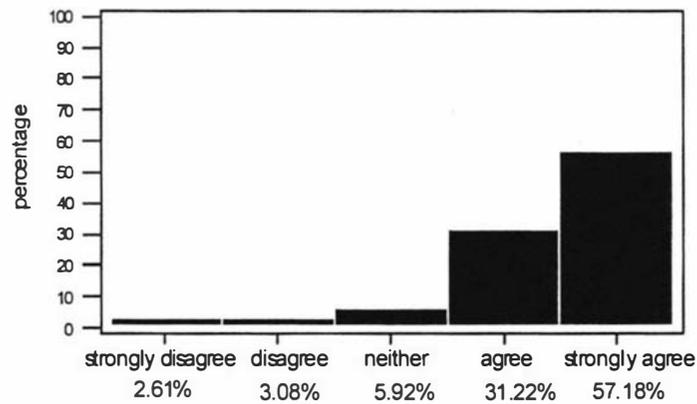
Q31 I felt I was involved with decisions that were made about my care while I was in labour



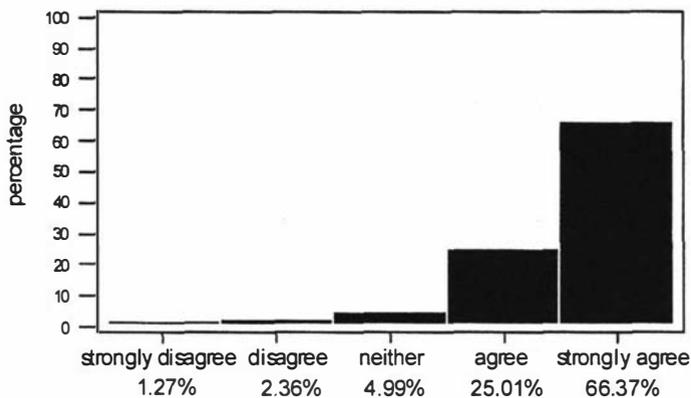
Q32 I felt it was fine to ask questions whenever I wanted to



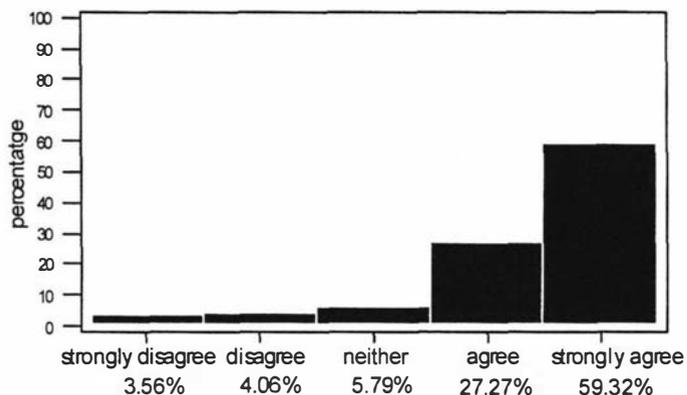
Q33 I got good explanations about what was happening



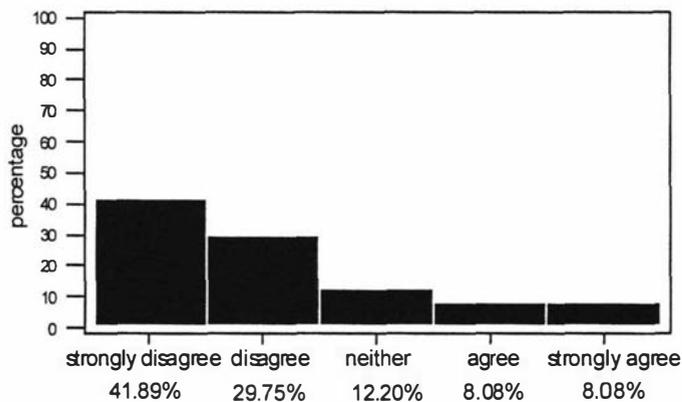
Q34 My support people/whanau were made to feel welcome

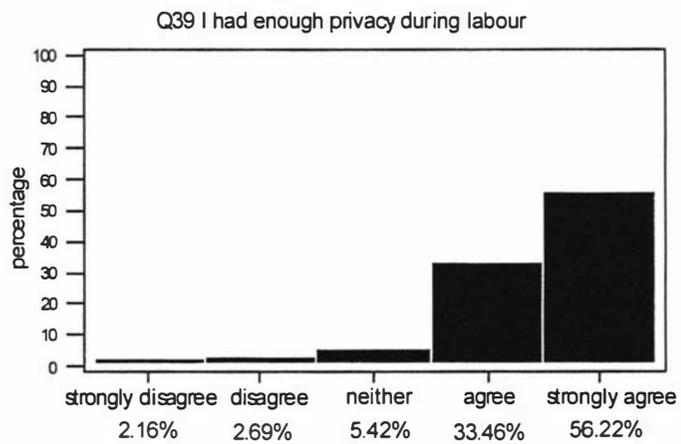
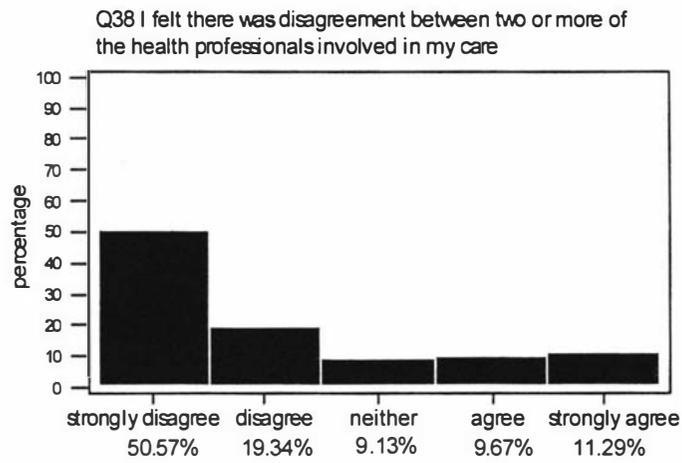
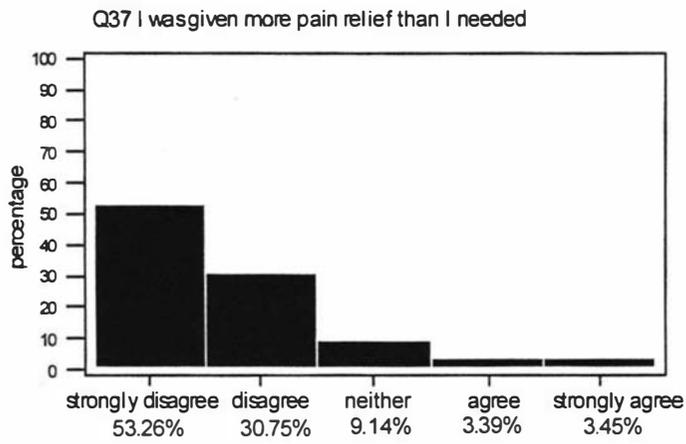


Q35 My wishes regarding pain relief were respected

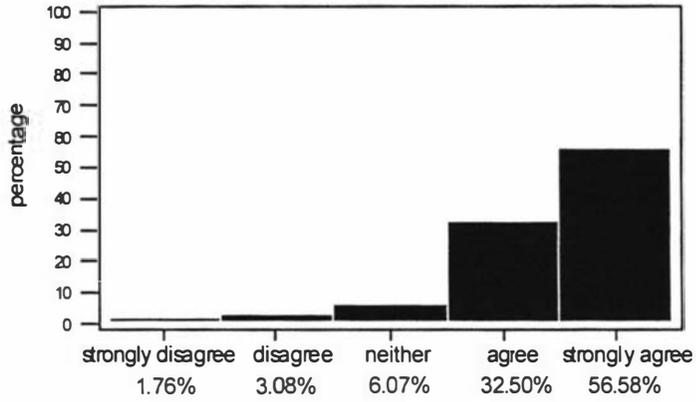


Q36 I needed more pain relief than I was given

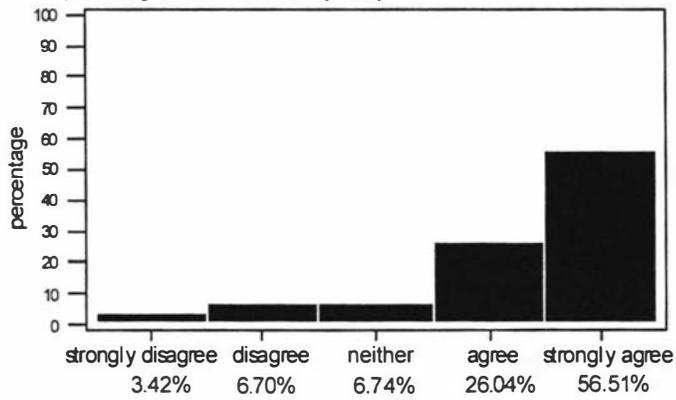




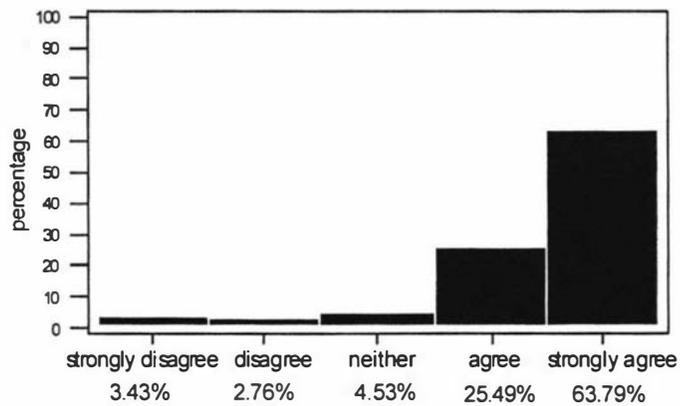
Q40 I had enough privacy at the time my baby was born

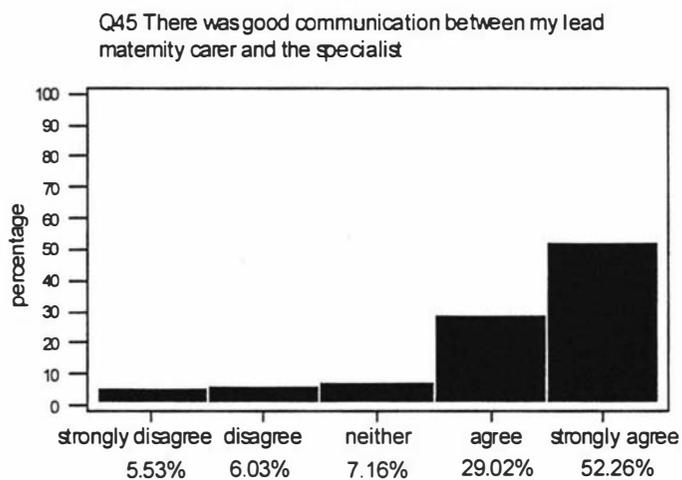
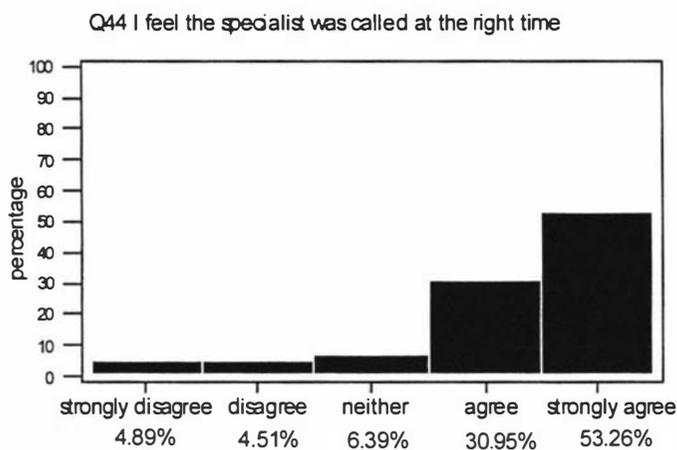
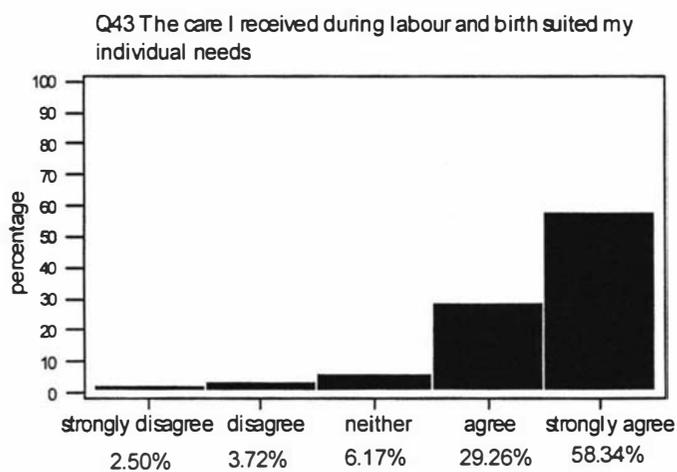


Q 41 I had confidence in all the health professionals who were providing care for me and my baby



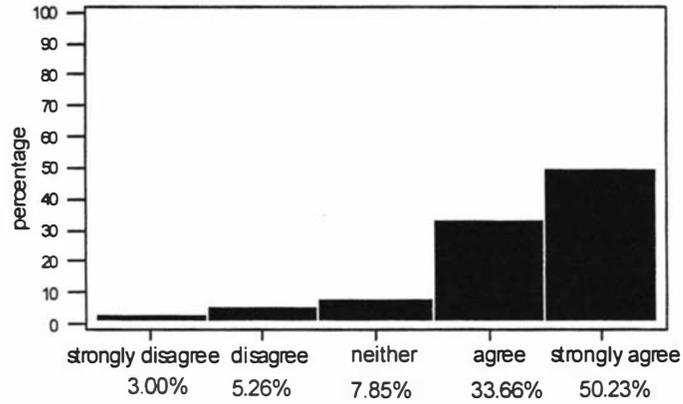
Q 42 I had confidence in at least one of the health professionals who were providing care for me and my baby



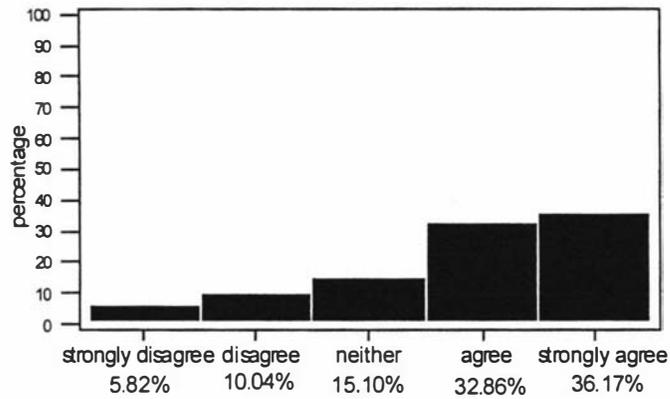


Section A.5C.3 After the Birth

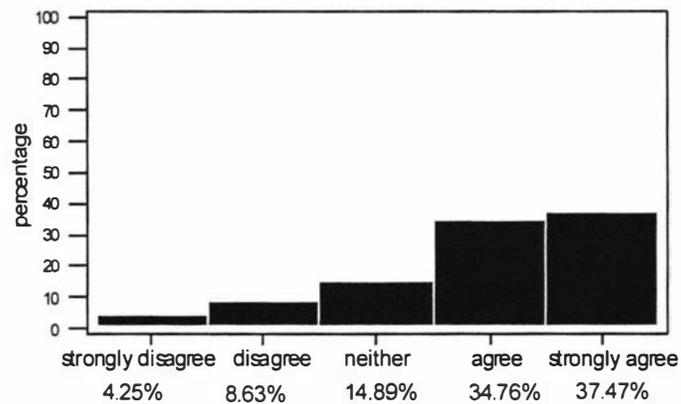
Q47 I was happy with the standard of care my baby received



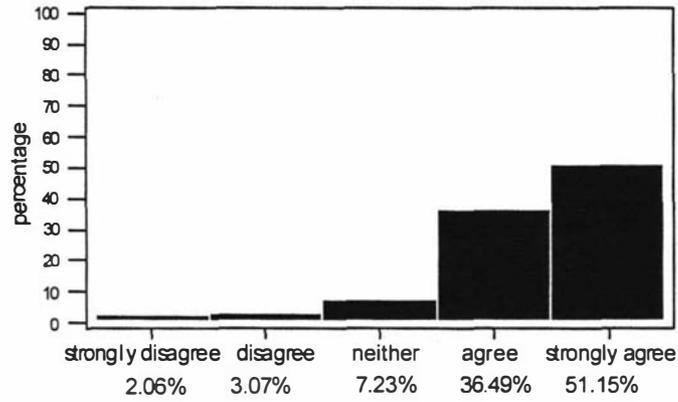
Q48 I got helpful advice about coping with the demands of a newborn baby



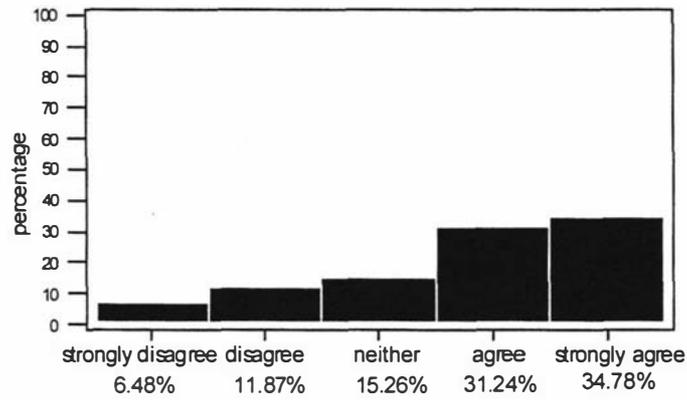
Q49 I got good advice about how to look after myself after the birth



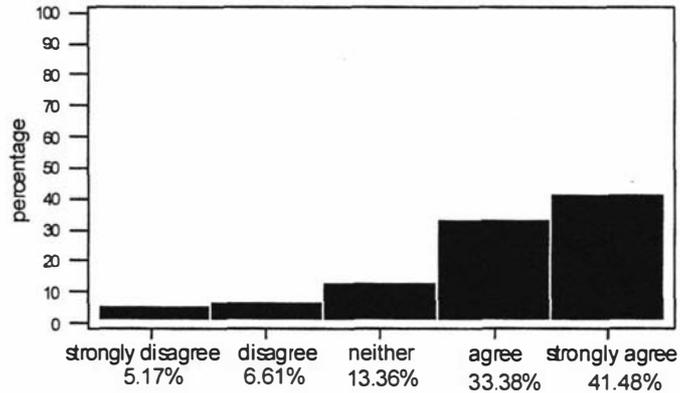
Q50 I felt I got good support from at least one health professional



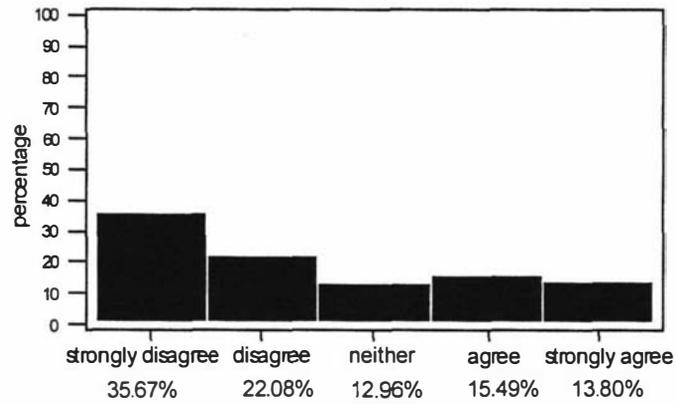
Q51 A health professional gave me good information about the emotional ups and downs that can happen after having a baby



Q52 The care I received after my baby was born suited my individual needs



Q54 I got conflicting advice about feeding from different health professionals



Q55 I got helpful advice about feeding from a health professional

