Midwifery Pay Equity claim

Changing the conversation

7 April 2022

Historical context

- **Early 20th Century:** Mostly home births with highly skilled midwives who worked autonomously.
- **Midwives Act 1904:** Regulated midwifery with midwifery training schools and registration in a State midwifery service. Hospital births encouraged and midwifery under direct control of medicine, at the time dominated by the emerging profession of obstetrics.
- **1957 changes:** Nursing curriculum incorporated a basic maternity component with these nurses registered as General and Obstetric Nurses; could register as midwives after six months extra training in a St Helen's hospital and an examination for State Registration.

- **Nurses Act 1971:** Removed the right of midwives to practice autonomously; midwifery largely subsumed by nursing, controlled by medicine, and displaced from a community-based profession into a hospital-based workforce with virtually all births in hospitals under the control of male GPs and obstetricians.
- **Nurses Amendment Act 1990:** Statutory recognition for midwives as "safe and competent practitioners in their own right" was the result of consumer pressure by women and the establishment in 1989 of the New Zealand College of Midwives; midwives gained the statutory right to prescribe drugs, order diagnostic tests, and direct-entry training.
- **Today:** The midwifery profession today is largely self-regulated (via the Midwifery Council) and midwives work autonomously in a similar manner to Nurse Practitioners, Dentists, and GPs.

Valuing midwives

- Midwives have a unique skill set and relationship with women, that engenders health promotion through pregnancy, childbirth, postnatally, and in the fostering of family well being.
- In addition to birthing, midwives promote and protect breastfeeding, an important health measure in life, critical to mothers and babies ongoing survival.
- A midwife's role is carried out in homes, primary, secondary and tertiary settings, every hour of every day.
- Midwives ensure better health outcomes with comprehensive guidance, astute practice and life-saving procedures of resuscitation.
- Midwives are of paramount importance in the realm of women's, babies and families' lives during a momentous time, facilitating the transition to healthy parenthood.
- Undervaluing of midwives' critically important skills puts each and every Kiwi in danger of a poorer start to life. It reduces breastfeeding rates and negatively affects parenthood which bodes ill for future generations.

New Zealand Midwifery in Crisis

New Zealand midwifery in crisis

- Chronic understaffing in almost all NZ maternity units
- DHBs unable to recruit or retain midwives
- Stress of working in hospital settings with increased complexity (e.g. obesity, diabetes, pre-term labour, women's expectations)
- Decades of very low numbers of midwifery students completing midwifery pre-registration programmes annually (TEC Report to Midwifery Accord)
- Difficulty recruiting from overseas and difficulty retaining them once in NZ; limited potential pool (most from the UK); active recruitment by Australian entities; NZ pay rates uncompetitive with Australia
- Low numbers of Return to Practice midwives – may be some improvement following Midwifery Accord initiative (Midwifery Council Workforce Report 2021)

Lack of investment in midwifery

- 10 – 15 years of under investment in workforce planning as lower priority placed on women's health
- Reliance on international recruitment, rather than "growing our own" midwives
- Lack of support for student midwives and new graduate midwives
- No access for midwifery students to Covid retraining funding (funding directed into male-dominated occupations despite majority of those displaced by Covid being women)
- Lack of career opportunities for many experienced midwives
- Invisibility of midwifery as a profession within the DHB culture (in a male-dominated hierarchy dominated by medicine, midwives have been invisible to those making decisions)

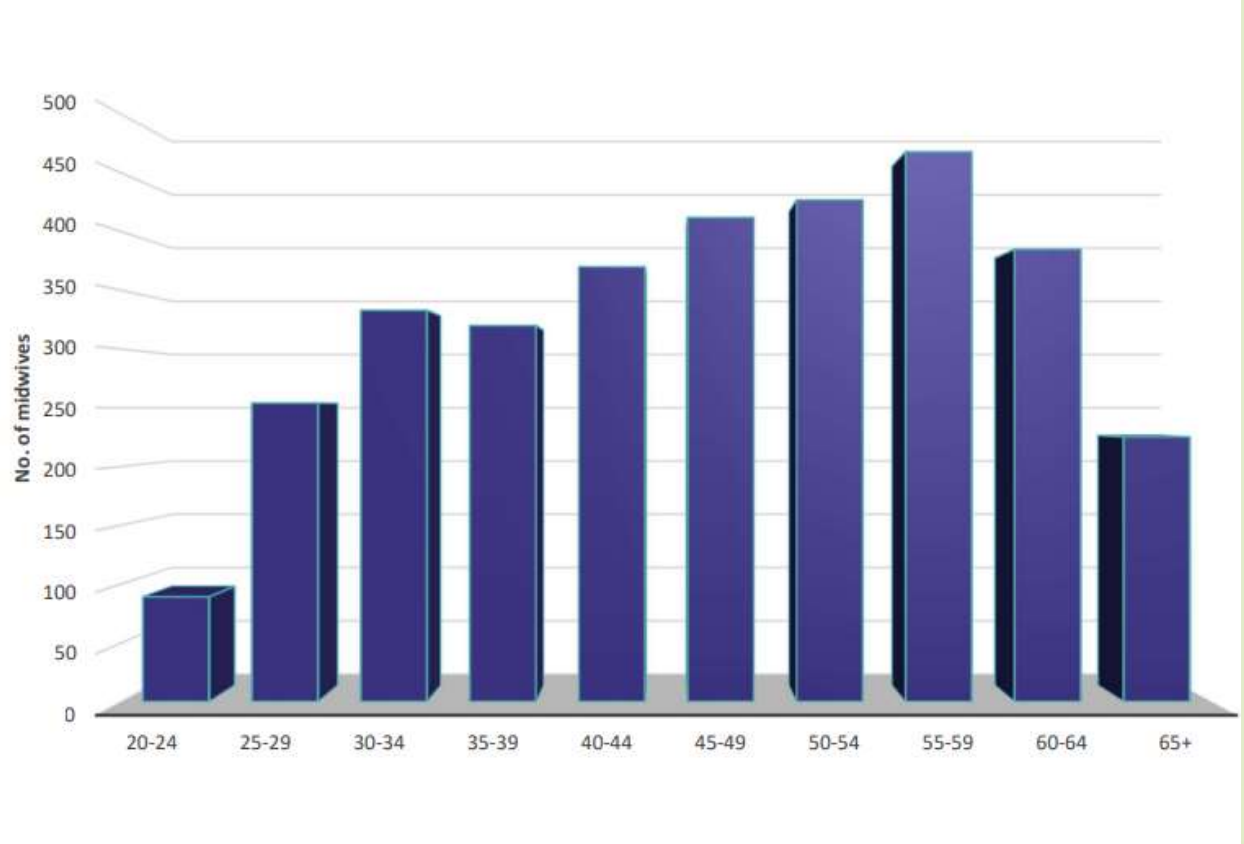
Changes that are making a difference

- Midwifery programmes are moving to 4 calendar years (rather than squeezing a 4 year programme into 3 calendar years)
- Funding from Midwifery Accord to:
  - ✓ Support for Return to Practice midwives
  - ✓ Introduction of Midwifery Clinical Coach roles
  - ✓ Increased support for Māori and Pasifika student midwives
  - ✓ Clearly defined Midwifery Career Pathway

All of this effort could be wasted if the pay rates for DHB midwives do not support retention.

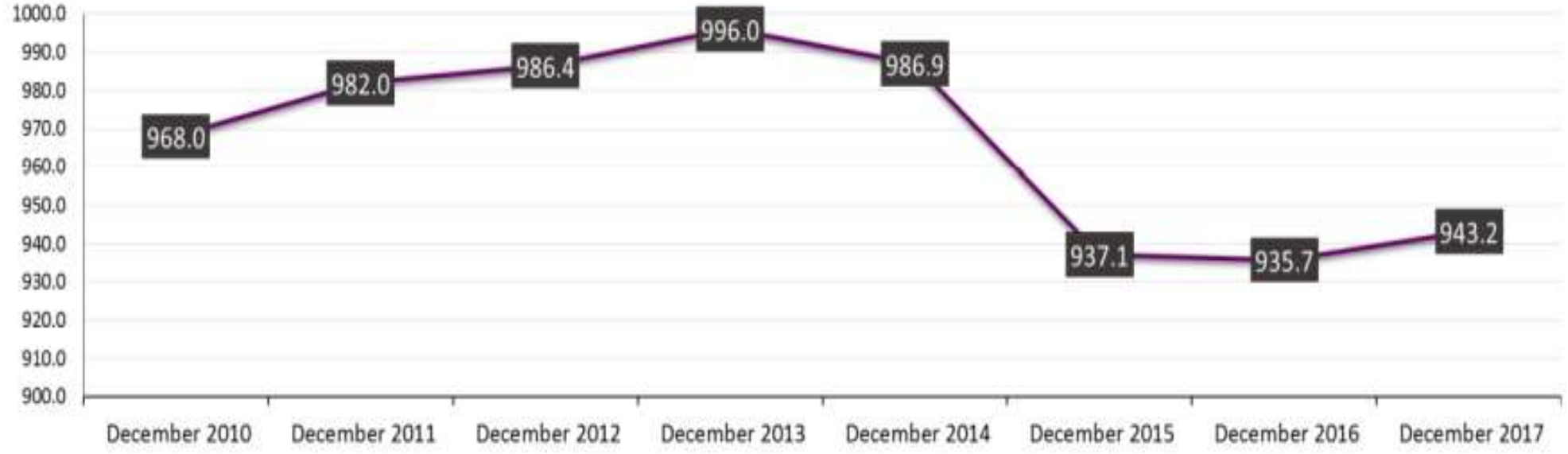
According to 2021 workforce figures, 58% of midwives were over 45, and only 21% were under 35.

Age of practising midwives
2021 Midwifery Workforce Survey MCNZ



Historical Reduction in FTE contributed to the Crisis

Figure 3 - DHB Midwifery Contracted FTE from 31 December 2010 to 31 December 2017



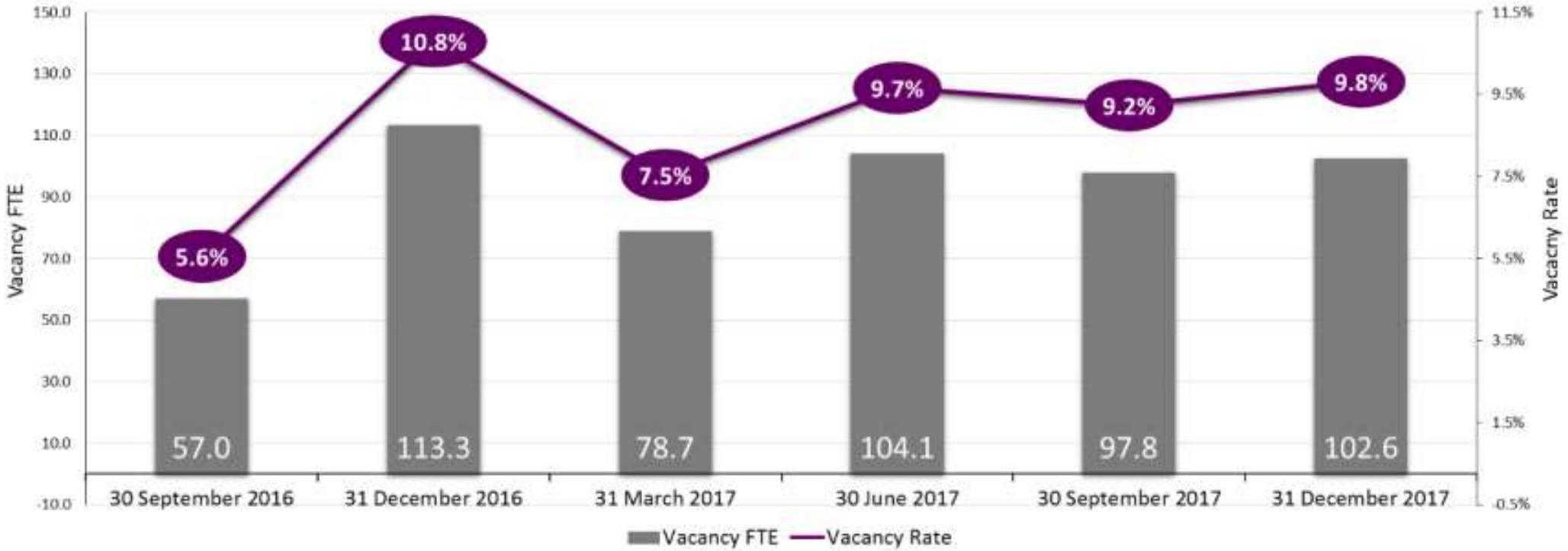
From December 2010 to December 2013 there were slight increases in the DHB midwifery FTE per 100,000 fertile population in New Zealand. However, since 2013 the DHB midwifery workforce density has been progressively decreasing. The December 2017 national density figure of 82.7 FTE DHB midwives per 100,000 fertile population is 11% lower than the 93.0 FTE figure in December 2013.

Figure 5 - Cumulative increase in DHB Midwifery FTE & the New Zealand Fertile Population (15 to 49 years) from 31 December 2010 to 31 December 2017

Fertile Population data sourced from StatsNZ

1. Overall Vacancy FTE and Vacancy Rates Reported by the 20 DHBs

Figure 21 - DHB Midwifery Vacancy FTE & Vacancy Rates from 30 September 2016 to 31 December 2017



Declining midwifery FTE while NZ population increases

- **Compare static DHB midwifery workforce to increase in NZ population below -**
- **NZ population increase**
- 2010 4 373 900 population
- 2017 4 767 600 population
- 2021 5 127 200 population
- 753 300 population increase in NZ in 11 years – 17.2% increase in the population with no significant increase in DHB employed midwives
- https://www.stats.govt.nz/indicators/population-of-nz

Limited career opportunities

- 74% DHB-employed midwives are Core Midwives (data provided by TAS)
- 8% DHB-employed midwives employed as Community Midwives or Caseloading Midwives in only a few DHBs
- Limited Senior Midwife positions available; only 18% DHB midwifery workforce, mostly in large hospitals
- Most Senior Midwife positions are paid on the lower grades of the senior midwife pay scale (83% Senior Midwives are on G4 or below)
- Very few midwives appointed to G7 or above

DHBs response to inability to employ enough midwives to safely staff maternity units

- Widespread recruitment of Registered Nurses to work in maternity due to lack of midwives – RNs have limited scope of practice in maternity and must work under the direction and delegation of a midwife (competency 4 Midwifery Council)
- Taking from one profession in crisis, i.e. nursing, to cover for another profession in crisis, i.e. midwifery.
- Care rationing due to midwifery shortage - inductions of labour and elective caesarean sections delayed.

Wage setting context

- **2005 NZNO pursued a fair pay claim** – led to 2004-2006 MECA increase - midwives' pay increased by 14% for Auckland and Canterbury, and 15-25% for other DHBs.
- Other unions, including MERAS, adopted the NZNO MECA as a base MECA and since then there have been two MECAs setting midwives' pay rates – the MERAS MECA and the NZNO Nurses and Midwives MECA
- Midwives' pay rates historically linked to that of nurses. The NZNO MECA has been negotiated ahead of the MERAS MECA and the DHBs' approach has been to offer wage rates negotiated with NZNO to MERAS
- Reluctance of DHBs to resolve issues in basic salary structure in MECA negotiations
  - steps in the core pay scale uneven and overlapping pay rates between grades in the senior pay scale.

Pay Equity processes

- **Midwives were found to be 94% comparable with GPs** - as a result of High Court case taken by the College of Midwives in 2015 on behalf of LMCs (self-employed midwives) job sizing used EJE tool.
- **Midwives Significantly Comparable to GPs and Nurse Practitioners** - PWC Report – Human Rights Tribunal, Ontario, Canada resulted in similar findings for Ottawa midwives
- **Senior Midwives employed by DHBs** are placed in grades based on a job sizing system specific to Senior Nurses and Senior Midwives that is a very blunt tool. The current Midwifery Pay Equity process is the first time an equitable job assessment has been used for DHB-employed midwives.
- EJE scores of core midwives' roles in the Midwifery Pay Equity claim highlight the comparability with Dentists and Scientists.

The cost of getting it wrong

- Further loss of confidence in the New Zealand political system
- Fails to attract people into the profession
- Fails to attract midwives from overseas
- Increasing levels of midwifery burnout and significant personal costs to health
- Increasing FTE vacancy in DHBs
- Increasing poor clinical outcomes

What we achieve by getting it right

- A process that is fair and reflects the pay equity principles
- Midwives know that their profession has been recognised for the skills and knowledge that they have as compared to male comparators
- Attracts people to the profession as they are fairly remunerated for their investment in their midwifery education, their knowledge and their skills
- Attracts midwives from overseas
- Attracts midwives to return to the profession

This is our one chance to get midwives paid fairly for their knowledge and skills – Let's get it Right!