**FAQs to support the Community Primary Midwifery Funding Model Presentation 3 Nov**

**What are the overall co-design recommendations?**

A community midwifery organisation that holds a national contract to support the workforce and fund contracted midwives via a blended payment model that approximates the real costs of services and meets the highly variable needs of women and workforce.

**What are the initial outcomes the new co-design funding model will achieve?**

* Enable more women and families to get quality midwifery care, where they live, when they need it
* Stabilise the workforce by providing fair and reasonable remuneration to community midwives that better recognises work done
* Enable midwives to use their clinical skills and professional judgement to assess need and scale the intensiveness of care to meet that need
* Build a system around self-employed midwives to support them to connect with the wider health and social sector and establish systematic continuous quality improvement processes.
* Introduce workforce incentives to drive the FTE and geographic distributions we need to ensure access for all women to quality services
* Introduce service incentives to turn the tide on rising unnecessary intervention rates and protect normal birth

**What are the specific features of a Blended Payment Model?**

* A model based on the approximate actual costs and value of running a community primary midwifery service as a business. The model pays for work done and appropriately values the unique nature and aspects (including on call) of being a community based midwife in New Zealand.
* Mix of regular fixed (monthly) payments and fee for service payments to provide a more stable and steady income stream for midwives
* Has mechanisms to compensate additional time and travel needed to support high/complex needs women based on the professional judgement of the midwife, but subject to stringent audit and review processes
* Reduces incentive to take very high or very low appropriate caseloads to maintain service quality
* Introduces workforce incentives to support recruitment, retention and redistribution to hard to staff areas and times of year

**What are the specific features of the National Community Midwifery Organisation?**

* Nationally consistent structures, governance and infrastructure for midwives underpinned by professional standards and quality assurance.
* Regional relationships to meet varying local need and support the development of regional initiatives and solutions
* Midwifery and woman driven focus with strong governance
* Would have experience, skills and knowledge to uphold and strengthen New Zealand Model of Care
* Driven by social investment and demonstrated social outcomes
* Responsible for quality assurance and service quality improvement
* Responsible for national and regional service integration
* Responsible for workforce support including locum service and IT infrastructure
* Could be bulk funded and hold an outcomes based contract to drive innovation

**The current funding model for midwifery is inequitably distributed with the highest need women attracting the least funding. How will the new model change this distribution and how quickly will the change happen?**

Midwives will be funded for the extra time and travel they provide to women with additional medical, obstetric or sociocultural complexity. This will enable midwives to be more responsive to individual circumstances. As soon as a new payment model is implemented (target October 2018), midwives will be able to claim these extra fees. We will also change the modular structure to ensure work completed in any part of the pregnancy is paid for, unlike the current model which only pays for work done from 17 weeks of pregnancy and is significantly weighted towards the birth attendance regardless of the time/work this takes.

**What will the model mean for midwives living in different parts of NZ?**

For all midwives, this new funding model will make providing individual women and their whanau with maternity services more sustainable by more closely funding the actual time spent. Rural and remote rural midwives will be able to claim additional travel and time to reflect the rural context but there may be a need for further support to provide services to their communities, as per most other health services which operate a different model in remote rural settings.

**How do the overall co-design recommendations address the urgent LMC midwifery workforce needs?**

1. The blended payment model enables the funding to follow the work. Midwives who spend additional time and travel meeting the needs of women will be able to recoup these costs. This makes service delivery more sustainable, and supports retention as midwives will be less likely to experience burn out. Midwives caring for women with greater needs will be able to make a full time income with a lower caseload, and as such a fair and reasonable number of hours per week. The blended payment model also proposes four workforce incentives:
2. recruitment (a one-off set up grant)
3. retention (a long service payment after 5 years of continuous service)
4. hard to staff region (incentive to care for women in hard to staff areas)
5. hard to staff time of year (incentive to care for women due in December and January).

These workforce incentives will address the urgent need for more midwives, especially in some areas. This will have an impact as soon as implemented.

1. The average hourly rate after business operating costs and including a projected acknowledgement of on-call time is $12.80 at present for a 47 hour week (or $42.02 before Business Costs and On Call Acknowledgement). As a response to this midwives are currently working extreme hours, working overseas for short periods or working across LMC and DHB work. Fair and reasonable remuneration, independently from how it is allocated, or who allocates it, will address the urgent need for more money and make community midwifery economically viable as a full time role for midwives. This will have an impact as soon as implemented.
2. The proposed national community midwifery organisation will also support the workforce with infrastructure, training, integration and representation. This will have an impact once the organisation is operational and functional (1-3 years).

**How will the new model be implemented?**

It is proposed to use iterative stages to implement the new funding and payment model. This phased approach will enable urgent workforce issues to be dealt with quickly via blended payment made under a transitional model in 2018/19 (year one).

A National Midwifery Organisation would be developed in year 2 and phased in during years 3 and 4.

**What was taken into consideration when developing the pricing information?**

* Detailed description of the work of an LMC Midwife
* Best practice/evidence based practice time allocation
* Actual time spent by workforce currently – Midwifery Survey Data & Midwifery Time Tracker Data
* Expert statements on assurance of process undertaken and findings

**What pricing methodologies were used?**

* Historic Pricing adjusted for inflation
* 1993 hourly rate for 1FTE before costs adjusted for wage and CPI inflation
* 1996 1FTE caseload before costs adjusted for wage and CPI inflation
* Pricing of comparable jobs – theoretical and actual
* Resident Medical Officer
* DHB employed Midwives
* General Practitioners
* Pharmacists
* Expert statement on strengths and limitations of pricing methodologies in this context

**How has a full time case load been defined?**

40 women giving birth per year is seen as a full time caseload averaged across the entire population of women who receive care from a midwife LMC.

This is based on an average of 54 hours per woman, which equates to an average of 42 hours per week (or 2160 hours per year).Within this national average we propose the following breakdown:

For straightforward cases (75% of population, 39,000 women), the average hours is 48, resulting in a full time caseload of 45 straightforward cases per annum

For women and families with some additional need (20%, 10,400 women), the average hours is 65, resulting in a full time caseload of 33 cases per annum

For women and families with significant additional need (5%, 2,600 women) the average hours is 96, resulting in a full time caseload of 22.5 cases per annum

In practice most midwives will have a caseload made up of a mix of level of need, but as discussed elsewhere this is heavily influenced by where the midwife lives and works so can no longer rely on a single fee level with ‘overs and unders’ to equalise out.

**What is the estimated cost of 1 FTE?**

Remuneration of the skills, risks and responsibilities of 1FTE caseload $170k per annum

Additional compensation for unique on call expectations - $30k per annum

Compensation of operating costs - $41k per annum

Total per FTE $241k

**What will it cost to set up a national community midwifery organisation?**

This has not been costed or factored into the overall pricing work at this stage, however a rough estimate is 2% of the overall budget, or $6.7m. This includes implementation, change management, infrastructure, operating costs and independent evaluation. This will be costed and staged in more detail if supported by the steering group.