

# Meeting Paper



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<b>Date:</b>	Tuesday 5 December 2017
<b>To:</b>	Community Primary Midwifery Funding Model Co-design Steering Group
<b>From:</b>	Joint Ministry / NZCOM Co-design Group
<b>Subject:</b>	Final recommendations and associated supporting papers
<b>For your:</b>	Information

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1. The Ministry has been working with the New Zealand College of Midwives (NZCOM) to co-design a new Community Primary Midwifery Funding Model.
2. The co-design work commenced in March 2017 following an interim settlement agreement reached by the Ministry and NZCOM to resolve the High Court proceedings against the Ministry submitted to the High Court by NZCOM in August 2015.
3. The Joint Ministry / NZCOM Co-design Group met on Monday 4 December 2017 to finalise the recommendations and associated supporting papers from the Joint Co-design Group to the Steering Group.
4. The following finalised papers attached for consideration of the Steering Group:
  - Presentation: *Paying and Funding the Community Centred Midwife in New Zealand*, delivered to the Steering Group on 3 November 2017
  - Community Midwifery Pricing Model: Report and Recommendations of the Community Midwifery Funding Co-design Project, November 2017
  - Community Midwifery Payment Model: Report and Recommendations of the Community Midwifery Funding Co-design Project, November 2017
  - Community Midwifery Funding Model: Report and Recommendations of the Community Midwifery Funding Co-design Project, November 2017
  - Frequently asked questions.
5. The Joint Ministry / NZCOM Co-design Group's recommendations, together with the rationale and expected benefits, are provided in the following table.

Signed on behalf of the Co-design Group:

Karen Gulliland  
Chief Executive  
New Zealand College of Midwives

Date: 4/12/17

Bronwen Pelvin  
Principal Adviser Maternity  
Ministry of Health

Date: 4 Dec 2017.

**Members of the Co-design Group**

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Co-design Group Recommendation	Rationale	Expected Benefits
<p>Fair and reasonable pay for LMC midwives, calculated as follows:</p> <ul style="list-style-type: none"> <li>• 1 Full Time Equivalent (FTE) set as an average of 54 hours per case and an average of 40 births per year (2160 hours per year, 42 hours per week excluding on call and urgent call outs) in consideration of minimum care requirements and distribution of population need</li> <li>• \$170,000 per annum for 1 FTE (excluding on call allowance and operating costs) for the scope of the work, in the context of the historic pricing of this role and in comparison to other roles with similar responsibility, risk and working conditions*</li> <li>• \$41,000 per annum as explicit compensation of the operating costs of 1 FTE LMC midwife*</li> <li>• \$30,000 per annum as explicit compensation of the on-call expectations of 1 FTE LMC midwife*</li> </ul> <p>* Set as a maximum price per midwife to reduce incentives for very high caseloads or individuals working significantly over 1 FTE. Further consideration of pro-rating this compensation for part-time workers is recommended.</p>	<p>The current funding and payment model underfunds LMC midwives.</p> <p>The sustainability and productivity of the community midwifery workforce is dependent on the total remuneration per FTE community midwife, as well as the way such remuneration is apportioned, reflecting the work done and the outcomes sought.</p> <p>Community midwifery is a complex and demanding occupation, which has increased complexity and scope since its inception. On call expectations for LMC midwives are unlike any other workforce, and are an under-recognised, but critical component of the role.</p> <p>In order to establish fair and reasonable remuneration the co-design group used multiple methodologies to establish the likely range within which remuneration should sit.</p>	<ul style="list-style-type: none"> <li>• A sustainable midwifery workforce</li> <li>• Improved workforce morale and increased productivity</li> <li>• Improved workforce recruitment and retention</li> <li>• Increased service coverage and quality</li> <li>• Improved outcomes for pregnant women and babies.</li> </ul>

Co-design Group Recommendation	Rationale	Expected Benefits
<p>A blended payment model is introduced for LMC midwives who do not wish to continue using the Notice, which incorporates the following elements:</p> <ul style="list-style-type: none"> <li>• fee-for-service fees for modules of care delivered</li> <li>• operating costs paid evenly throughout the year</li> <li>• explicit compensation to recognise the unique on-call requirements of community midwifery care</li> <li>• financial incentives that support recruitment, retention and workforce distribution</li> <li>• fees claimable for additional time and travel to women as they need it, based on professional judgement</li> </ul> <p>Fees and payments are reviewed periodically so that they drive best practice and compensate the realities of the work.</p>	<p>There are inequities in maternal and perinatal health outcomes across different population groups.</p> <p>Under the current payment model, the funding does not follow differential need or adequately compensate work done.</p> <p>The blended payment model is designed to approximate the actual costs of work done, drive desired workforce distribution and behaviour, and minimise perverse incentives associated with each of the component payment models.</p>	<ul style="list-style-type: none"> <li>• Increased workforce recruitment and retention through cost recovery and incentives</li> <li>• Safe, manageable, caseloads (by eliminating existing perverse incentives)</li> <li>• Enables a midwifery model that is more responsive to client need</li> <li>• Improved access by funding first trimester care and miscarriage care, and by incentivising the workforce to cover current hard-to-staff areas and times of year (holiday periods)</li> <li>• Improved safety and quality by eliminating the disincentive to call a back-up midwife, also reducing demand on DHB core midwifery staff</li> <li>• Increased use of home and primary facility births, resulting in improved outcomes and experience for women and families, and cost savings from reduced use of hospital services</li> <li>• Reduced inequities and improved maternal and perinatal health outcomes.</li> </ul>

Co-design Group Recommendation	Rationale	Expected Benefits
<p>A national organisation be developed in partnership with NZCOM and contracted by the Ministry of Health, to:</p> <ul style="list-style-type: none"> <li>• Contracts for midwifery services and pays LMC midwives who do not wish to continue using the Primary Maternity Services Notice pursuant to Section 88 of the Public Health and Disability Act 2000 (the Notice)</li> <li>• negotiates fees and coverage of services annually or at agreed time frames with the Ministry on behalf of LMC midwives</li> <li>• facilitates community midwifery services at national and regional levels – including work with DHBs and other providers</li> <li>• provides workforce support and locum cover</li> <li>• coordinates the IT infrastructure, interfaces and reporting</li> <li>• implements quality assurance and service improvement defined by the profession.</li> </ul>	<p>The current funding model is outdated and burdensome for the Government and for LMC midwives. It provides perverse incentives and is inflexible.</p> <p>A national organisation will provide functions that are currently missing from the status quo, including infrastructure to support LMC midwives to connect with the wider health and social system and operate as a coordinated workforce providing a consistent high-quality service across New Zealand.</p> <p>This new model is likely to receive widespread support from midwives.</p>	<ul style="list-style-type: none"> <li>• Clear and transparent accountability for service coverage, integration, and workforce support</li> <li>• Better support for LMCs working with pregnant women with multiple complex needs</li> <li>• Consistency and economies of scale in systems resulting in system efficiencies</li> <li>• Workforce support and planning resulting in improved service coverage and back-up support</li> <li>• National and regional representative voice for LMC midwifery services resulting in improved communication and service integration</li> <li>• Reduced administrative burden on individual LMC midwives resulting in increased productivity and sustainability.</li> </ul>

Co-design Group Recommendation	Rationale	Expected Benefits
<p>A staged implementation approach:</p> <ul style="list-style-type: none"> <li>the new blended payment model is developed and operational by October 2018, using existing sector capability</li> <li>immediate scoping of a national locum service to enable LMC midwives to access fair and reasonable personal and professional leave</li> <li>Immediate urgent relief measures to retain the current workforce</li> <li>MOH devolves the operation and responsibility of the blended payment system to a national organisation by July 2021</li> </ul>	<p>There is an urgent need to attract, recruit, and retain midwives in New Zealand.</p> <p>The midwifery workforce exit rate is 17% per annum nationally, compared with 11% for nursing and 4% for general practitioners, and is up to 37% in some regions. Forecasting places us 250 FTE short in 2018 to maintain existing service levels with the current entry and exit rates. Service modelling estimates around 300 additional FTE over the current level is required to provide a service that is responsive to population need.</p> <p>While there are a number of providers/vendors that currently cover some of the aspects of the support funding model support functions recommended, there is not an existing national provider or ready market for us to procure the full scope of services.</p>	<p>A staged approach enables us to respond to the existing workforce pressures quickly, using existing sector capacity and resources as an interim arrangement until the full suite of functions can be provided through a national organisation.</p>