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# Community Midwifery Pricing Model

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# Report and Recommendations of the Community Midwifery Funding Co-design Project

**November 2017**

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## Executive summary

This report sets out the process taken and the findings of the pricing work stream of the Community Midwifery Funding Co-design Project based on work carried out by the Ministry of Health and New Zealand College of Midwives co-design team. This exercise was commissioned by the Project Steering Group to consider fair and reasonable remuneration for the work of a community midwife.

Work with remuneration experts, public service experts including the State Services Commission and midwife experts has established that no single existing job evaluation and remuneration approach is sufficient or appropriate to form a fair and reasonable price for self-employed lead maternity carer (LMC) midwifery.

Instead the co-design team has used multiple methodologies to establish the work of the LMC, the likely range within which remuneration should sit, a fair estimate of 1 Full Time Equivalent (FTE), and the other costs involved with delivery of the current, preferred, model of care.

Our key findings are:

* The role of a community midwife has increased in complexity and scope since its inception
* LMC midwives currently deliver on average 53 contact, non-contact and travel hours per woman over the course of care (from early pregnancy to 6 weeks postpartum) and carry an average caseload of 47 women per year.
* If 40 hours per week is used as a benchmark for 1 FTE, midwives currently work on average 1.25FTE with some working upwards of 2 FTE, excluding on call expectations.
* LMC midwife actual operating costs are similar to recent Ministry of Health (2013) and Public Service (2017) estimates.
* On call expectations for community midwives are unlike any other workforce, and are an under-recognised, but critical component of the role.

Our recommendations are:

* 1 FTE is set at an average of 54 hours per course of care and an average of 40 births per year (2160 hours per year, 42 hours per week excluding on call time and urgent call outs).
* Additional time and travel, recognising the need some women have for additional midwifery care, is compensated over and above a straightforward case of 48 hours, in increments, up to twice a straightforward case (96 hours).
* One-quarter of the population is likely to require some additional time and travel and 5% of the population is likely to require significantly more time and travel.
* Fair and reasonable remuneration for the scope of the work, in the context of the history of this role and in comparison to other roles with similar responsibility, risk and working conditions is $170,000 per annum per FTE, excluding on call and operating costs.
* Fair and reasonable remuneration for the unique on call expectations is $30,000 per annum. This includes compensation for time on call and call outs.
* Fair and reasonable operating costs are $41,000 per annum.
* Other factors to support the sustainability of the workforce are urgently progressed including a national locum service, recruitment and retention incentives, and separate payment for single service episodes including miscarriage care and second midwife birth attendance.

## Introduction

A core component to the work being undertaken through the joint co-design project between the Ministry of Health and the New Zealand College of Midwifes (NZCOM) concerns fair and reasonable remuneration for the work of a community midwife Lead Maternity Carer (LMC).

The sustainability and productivity of the community midwifery workforce is dependent on the total remuneration per full time equivalent community midwife as well as the way such remuneration is apportioned reflecting the work done and the outcomes sought.

Work with remuneration experts, public service experts including the State Services Commission and midwife experts has established that existing job evaluation and remuneration approaches are each insufficient to form a fair and reasonable price for self-employed lead maternity carer midwifery. This is due to:

* the unique form of self-employment and single source of government originated income
* the working conditions including 24/7 on-call expectations and the real impact of accessing flexible, reasonable and properly valued leave solutions.
* the unique nature of continuity of care midwifery and thus the lack of local or international market
* the unique gendered nature of the workforce and clients and the opportunity for inherent bias to build up over time through institutional and personal discrimination
* the systemic undervaluation of relationship-based services in existing methodologies.

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. This approach was reviewed and approved by State Services Commission and the Ministry of Health Steering Group in September 2017.

The purpose of this report is to present the results of these methodologies to assist the Ministry of Health to develop a Budget 2018 bid for additional funding for the Primary Maternity Appropriation to recognise cost and service pressures.

The document sets out the following components:

The work of a community midwife

* Description of work
* Significant scope changes since the creation of the role
* Employment context – costs and benefits

Pricing methodologies

* Historic pricing adjusted for inflation and significant scope change
* Pricing of comparable jobs
* Expert statement on strengths and limitations of methodologies in this context.

Calculation of 1 Full Time Equivalent

* Best practice/evidence based practice time allocation
* Actual time spent by workforce currently
* Proposed methodology of recognising caseload variance.

Calculation of costs of providing community midwifery

* Pricing of operating costs
* Pricing on-call expectations
* Pricing of a national locum service.

## The work of a community midwife in 2017

### Description of work

Community LMC midwifery is a complex and demanding occupation. It requires equivalent to a four year degree to achieve the starting qualification (plus an Intern Year encompassing the First Year of Practice), and a further 4-5 years of clinical practice and continuing professional education and mentoring to gain full proficiency.

LMC midwives provide continuity of care 24 hours a day to pregnant women from early in pregnancy to six weeks after the baby is born – up to eight and a half months of continuous care. They provide proactive case management over an extended period across 40-50 pregnancies per annum that range from straightforward to complex. The current average annual caseload for a community midwife in New Zealand is 47.

LMC midwives are required to apply significant judgement and undertake complex problem solving in managing and determining care requirements. They provide care autonomously under their own responsibility when pregnancy and birthing experience is normal. When secondary or tertiary care is required, LMCs work with DHB-employed core midwives, the hospital obstetric team, anaesthetists and paediatricians and frequently continue to provide care.

LMC midwives interact and engage with pregnant women and their whānau in their care, and require comprehensive and diverse interpersonal skills and empathetic, adaptive, flexible and responsive communication. They require the ability to develop rapport and engagement quickly and anticipate, prioritise and respond to needs early.

LMC midwives develop a trusting relationship with women, act as a trusted long-term advisor; having a high level of influence over women’s decision making processes. In partnership with women they develop and facilitate partner and family education to support informed decision making.

LMC midwives create working relationships with other midwives, other health professionals, and a wide range of social agencies and professionals. They require negotiation and advocacy skills; continuing to engage women and other health professionals in constructive relationships when there may be resistance to advice, reluctance to engage with care or conflicting views, while balancing competing priorities to ensure best outcomes for women and their babies.

There are demanding physical, sensory and emotional requirements of the job including; professional autonomy, working in women’s homes, clinical competencies and skills to provide hands-on care and clinical procedures such as suturing, heavy lifting, exposure to hazardous materials, driving in all conditions, and long and unpredictable hours. In addition, LMC midwives are frequently required to provide acute assessment and manage emergency treatment.

LMC midwives are required to be available on call 24/7 for women in the midwife’s own caseload and her back up colleague’s caseload (when back up is having scheduled time off or are unavailable). They need to be able to re-prioritise and reschedule work at short notice as the nature of labour and birth or emergency attendances is unpredictable.

A full analysis of the role and requirements is provided in Appendix One.

### Significant scope changes since the creation of the role

The scope of midwives’ obligations and responsibilities has been incrementally and significantly increased since 1993, both through changes to the relevant Notice and through changes outside the Notice. These changes have impacted significantly on the scope of responsibilities and obligations of LMC midwives. A timeline summarising significant scope changes is attached as Appendix Two.

Notable changes include:

* The expectation for LMC midwives to engage women and provide care prior to 14 weeks of pregnancy (first trimester care), this results in additional contact and non-contact time, additional time on-call per client and additional work related to threatened and actual pregnancy loss.
* The funding models implemented by the early Notices in 1993, 1996, 1998 and 2002 were developed based on the assumption that LMC midwives would be reimbursed for providing care for normal and healthy pregnancies and births and as such had no capacity to provide additional care based on complexity, risk or need. However this expectation of ‘normal’ gradually changed over the years and LMC midwives have provided care to an increasing larger proportion of women, including women with medical and social complexity. Midwives served 40% of the birthing population in 1999 rising to 88% of the birthing population in 2016.
* In some areas of high deprivation there are likely to be higher numbers of pregnant women who have high complex social needs and require additional support. This has limited the ability of some LMCs to balance their caseload and the ability of women to access LMC care.
* DHB maternity services have become increasingly burdened and as a result, transfer the responsibility for certain care situations to the community workforce– for example fetal growth restriction, maternal hypertension, maternal diabetes, maternal obesity, and twin pregnancy. This results in LMC midwives needing to provide more monitoring, attend more emergency situations and undertake more complex coordination including more documentation, referral and follow up.
* Additional public health screening and education expectations as set by the Ministry of Health including: new tests; new screening programme for fetal anomalies and education around safe sleep, mental health, alcohol, tobacco, iodine, vitamin D; gestational diabetes, and healthy weight gain; new immunisation protocols including influenza, pertussis and rotavirus; and new professional expectations such as Worker Safety Checks, GROW charts and introduction of new information technology and reporting expectations.
* The impact of New Zealand’s changing demography, in particular the higher rates of social and/or medical complexity for maternity cases, requires LMC midwives to spend more time with the woman and her baby to ensure they receive the appropriate level of care taking into account their higher needs.

### Employment context – costs and benefits

LMC midwives are considered self-employed for tax purposes. Self-employment conveys benefits and costs that are different to an employed workforce. As summarised in the table below, a number of these benefits are not received by LMC midwives due to the nature of the work and the limitations under the Section 88 agreement. Under the current model, the real costs of self-employment significantly outweigh the benefits.

|  |
| --- |
| **Benefits of Self Employment** |
| Professional autonomy | Applicable |
| Tax benefits – vehicle and home office | This is not applicable as solely a benefit for self-employment as an employed person using a personal asset (vehicle or home) for business purposes will have access to compensation from their employer (including reimbursements for travel expenses, home office costs and communication expenses usually as a tax free allowance) |
| Choosing your own hours of work | Not applicable due to 24/7 nature of midwifery work (relationship and continuity of care based) and birth – two thirds of babies are born outside of normal office hours. |
| Ability to increase income through co-payments and business efficiencies | Not applicable as model of care is fixed and co-payments are prohibited under Section 88 legislation and the expectation of universal, publically funded maternity services in New Zealand It is also important to note the fact that there is an unequal balance of negotiating power in the contracting arrangement between the Government and the individual Community Midwife. |
| Choice of client | Not applicable in small communities where there are often workforce shortages and LMC midwives feel professionally obligated to care for all women seeking their care, or for new graduate midwives who are building up their caseloads |
| Tax Deductibility of all Business Costs | Not applicable as the funding amount of $41,000 received to cover business costs would also be taxable therefore leaving business costs both cash and taxation neutral. |

|  |
| --- |
| **Costs of Self Employment** |
| No commercial hourly contract rate loadings for annual leave, statutory leave, sick leave, bereavement leave, professional development leave and limited ability to take proper leave expectations because of the workforce crisis.  |
| No statutory leave or additional pay rate if working statutory holidays or called back on annual leave days |
| Contractor bears full cost and responsibility for liability, health & safety and professional development |
| Contractor bears full cost of infrastructure and operating costs required to enable service delivery |
| Contractor is solely responsible for management and administration of their business with limited ability (due to current income levels) to source and pay for proper support |
| Unlike most contractors, midwife has no ability to negotiate terms of contract or price |

### Co-design findings on the work of a community midwife in 2017

* Community LMC midwifery is a complex and demanding occupation that where outcomes rely heavily on a strong interpersonal relationship and near continuous availability over a period of eight months or more per client.
* LMC midwives provide care to more than twice the proportion of the population now than when the current funding model was implemented in 1993 and the current payment model was implemented in 1996 (88% in 2016, compared to 40% in 1999).
* Alongside this, there have been significant population demographic and population health shifts, such as rising levels of obesity, a rising proportion of births to families living in high deprivation and an increase in births to women over 40 years.
* LMC midwives have also had significant additions to their scope and volume of work through incremental additions based on new evidence and Government priorities.
* As such, LMC midwives now manage significantly more medically and socially complex cases, and carry significantly more care obligations and responsibilities since the current funding model was implemented in 1993 and the current payment model was implemented in 1996.
* LMC midwives work as self-employed contractors. This conveys autonomy which is highly valued by the workforce, however under the current model, the costs of self-employment significantly outweigh the benefits.
* Rural (and remote rural) LMC midwifes not only provide a quality maternity service to their region but also provide emergency response in the absence of any other service. The midwifery requirements of rural and remote regions have not been comprehensively considered or costed in this report. There is a need for a more tailored and detailed review as to how best structure, fund and deliver varying regional requirements to continue to ensure access to maternity service for all woman.

## Pricing methodologies

### Historic pricing adjusted for inflation and significant scope change

The co-design team reviewed all available documentation leading to the creation of the 1993 and 1996 funding and payment models. It is not clearly evident if and how certain costs and work were acknowledged. We are unclear whether the cost of the on call component of the New Zealand community midwifery model of care was objectively calculated when looking at valuing the assurance of service aspect of midwifery in the community. Furthermore, it is not clear what assessment and amounts (if any) was completed and what compensation was allowed for non-contact care and administration hours.

#### 1993 Maternity Benefits

Community midwives were first recognised in 1993, through the Maternity Benefits Tribunal. This set an hourly rate for continuity of care midwifery of $52 per hour, with certain exceptional services being claimable at $104 per hour. This funding was expected to cover all remuneration, operating and business costs. Travel costs (including time and mileage allowance) was paid at $1 per kilometre.

Best practice time allocation for a straightforward caseload (no exceptional circumstances claimed) was 37.5 hours per case with a recommended caseload of 40-50 (midpoint 45). We have estimated standard travel at 12,500 km per annum at $1 per km. This was an approximate income of $100,500 before costs and tax, for a straightforward caseload, ranging up to $126,500 for a complex caseload when exceptional circumstances claims are included.

Application of cost and wage pressures since 1993 results in the following ranges:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **1993 Price** | **Index Movements from 1993 to June 2017** | **Projected Index Movements Oct 2017 to June 2018** | **Total****Index****Movement** | **Expected Hourly Rate** **1 July 2018** |
| **Business Costs Recovery Rate** | 30% | $15.60 | Increase By 64% | Increase by 1% | Increase by 65% | $25.74 |
| **Wage Costs Recovery Rate** | 70% | $36.40 | Increase By 102% | Increase by 1.5% | Increase by 103.5% | $74.07 |
| **Straight Forward****Hourly Rate** |  | **$52.00** |  |  |  | $99.81 |
|  |  |  |  |  |  |  |
| **Straight Forward Hourly Rate adjusted for Additional Time Estimate** |  | $57.40 |  |  |  | $110.56 |
|  |  |  |  |  | 30% | $129.75 |
| **Travel Reimbursement** | 12,500 kms per Annum @ $1 per km | $12,500 | Increase By 64% | Increase by 1% | Increase by 65% | $20,600 |

Given approx. 30% of a community midwife’s income covers business operating costs, we have adjusted 70% of the income at wage inflation plus 30% at general inflation. This results in an hourly rate of $99.81 plus travel at $20,600 resulting in a 1FTE income $190,000 per annum, before costs and tax for a straightforward caseload, ranging up to $239,000 for a complex caseload. This excludes any additional scope added between 1993 and 2018.

The additional scope and complexity due to changes in the population and in the service expectations between 1993 and 2018 is conservatively estimated at 10% and could be up to 30%.

This results in a 2018 price for 1FTE of between $209,000 and $247,000 for a straightforward caseload and between $262,900 and $310,700 for a complex caseload.

#### 1996 Section 51 Notice

The LMC payment model was significantly shifted in 1996 when the move was made from hourly rate to capped modular fee for service. This set a fee for service for continuity of care midwifery of per antenatal, labour and birth and postnatal care episode, with certain exceptional services (with significantly reduced accessibility as compared to the 1993 maternity schedule) as additional fees. This funding was expected to cover all remuneration, operating and business costs for the entire course of care. The new funding criteria resulted in a 39% decrease in cost per case - the case rate for a straightforward case reduced from $1,950 in 1993 (37.5 hours per client at $52 per hour) to $1600 in 1996 (equivalent to an hourly rate of $42.67). There was also a significant reduction in travel reimbursement where travel costs were limited to rural travel only.

The amount per total straightforward pregnancy, birth and postnatal episode was set at $1600. Best practice time allocation for a straightforward caseload (no exceptional circumstances claimed) remained 37.5 hours per case with a recommended caseload of 40-50 (midpoint 45). This was an approximate income of $72,000 before costs and tax, for a straightforward caseload.

Application of cost and wage pressures since 1996 results in the following ranges:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **1996 per Case Rate** | **Index Movements from 1996 to June 2017** | **Projected Index Movements Oct 2017 to June 2018** | **Total****Index****Movement** | **Expected per case** **1 July 2018** |
| **Business Costs Recovery Rate** | 30% | $480 | Increase By 52% | Increase by 1% | Increase by 53% | $734 |
| **Wage Costs Recovery Rate** | 70% | $1120 | Increase By 89% | Increase by 1.5% | Increase by 90.5% | $2,133 |
|  |  | **$1600** |  |  |  | $2868 |

Given approx. 30% covers business operating costs, not wage costs, adjustment of 70% at wage inflation plus 30% at general inflation, the per case rate is estimated at $2868, resulting in $129,060 per annum, before costs and tax for a straightforward caseload ranging up to $131,278 for a more complex caseload. This excludes any additional scope added between 1996 and 2018.

The additional scope and complexity added between 1993 and 2018 is conservatively estimated at 8% and could be up to 25%, giving a range of $139,385 to $161,325 for a straightforward caseload.

### Pricing of comparable jobs

Formal job evaluation using comparators or a hierarchy of comparators (as per Pay Equity Principles) has not been completed for this role due to advice received by State Services Commission, Ministry of Health Employment Relations experts and one of the two external remuneration experts agreeing standard job evaluation methodologies were flawed in this context and not recommended (see expert statement).

Instead, this section undertakes informal comparison of a number of roles that share similarities with the work of a LMC midwife, at the mean length of service (6 years). The relative value of the comparator roles compared to the LMC role has not been formally assessed as part of this project.

On call and business operating costs have not been allowed for in these calculations or any scope of work adjustment.

|  |  |  |  |
| --- | --- | --- | --- |
| **Comparator** | **Similarities** | **Differences** | **Price range** |
| **Employed resident medical officer**, 45-50 hours per week, midpoint of experience band (6 years)[[1]](#footnote-1). | Responsible for complete care for a number of patients at once. Similar risk of exposure to hazards. Works as part of a multidisciplinary team. Similar years of on the job experience. Similar expectations in use of technology & maintaining clinical records. | Does not work autonomously (reports to Senior Medical Officer).Managed predictable rostered hours only, and less time on call. Ability to access comprehensive administration support. No travel, hospital setting only. Two additional years of formal education. Broader scope of practice. Not expected to concurrently run a business. Professional registration and indemnity insurance costs are paid by employer. | $118,910– to $121,839 + 11 days statutory leave or statutory pay+ 30 days annual leave, and up to 30 accumulating days sick leave+Tools of trade and multiple related expenses and allowances+ Significant additional call out and on call payments including telephone contact+ 6 weeks education leave, up to $6,500 conference attendance+ travel expenses/mileage if appropriate+ 6% Kiwisaver employer contribution |
| **Employed General Practitioner**, 40+ hours per week[[2]](#footnote-2)[[3]](#footnote-3) | Responsible for complete care for a number of patients at once. Works autonomously to deliver primary care. Works as part of a multidisciplinary team. Similar years of on the job experience. Similar expectations in use of technology & maintaining clinical records. | More variance in range of patient needs (wider than maternal/infant). Fewer urgent and emergency situations. No on call. Predictable hours. Two additional years of formal education. Not expected to concurrently run a business. Less requirement to perform clinical procedures on a regular basis. | $171,000 - $180,000 + 6% Kiwisaver employer contribution+ statutory leave or statutory pay+ 30 days annual leave, minimum of 9 days sick leave |
| **Contractor General Practitioner**, 40+ hours per week | Responsible for complete care for a number of patients at once. Works autonomously to deliver primary care. Works as part of a multidisciplinary team. Similar years of on the job experience. Similar expectations in use of technology & maintaining clinical records. Similar self- employment context. | More variance in range of patient needs (wider than maternal/infant). Fewer urgent and emergency situations. No on call. Predictable hours. Two additional years of formal education. Less requirement to perform clinical procedures on a regular basis. | $190,000 - $203,000 |
| **Self-employed General Practitioner (practice partner)**, 40+ hours per week (2016 summary workforce survey – insert reference) | Responsible for complete care for a number of patients at once. Works autonomously to deliver primary care. Works as part of a multidisciplinary team. Similar years of on the job experience. Similar expectations in use of technology & maintaining clinical records. Similar self- employment context (owner operator). | More variance in range of patient needs (wider than maternal/infant). Fewer urgent and emergency situations. No on call. Predictable hours. Two additional years of formal education. Less requirement to perform clinical procedures on a regular basis. | $201,000-$225,000  |
| **Employed community case loading midwife in a rural DHB** (actual price required to attract a midwife to this position)[[4]](#footnote-4) | Same community and home-based antenatal and postnatal services. Same education and experience. | Rostered time off. Statutory, sick and study leave. No labour and birth attendance. Not expected to concurrently run a business. Professional registration and indemnity insurance costs are paid by employer. Supported by organisational systems and processes | $160,000 + 6% Kiwisaver employer contribution+ statutory leave or statutory pay+ 30 days annual leave, minimum of 9 days sick leave |
| **Employed community case loading midwife** (Multi-Employer Collective Agreement (MECA) price)[[5]](#footnote-5) | Same community & home based postnatal services. Same qualification and experience.Works as part of a structured team with provisions which support regular rostered time off, and organisational policies and systems which support the role. | Rostered time off call. Statutory, sick, study leave. All equipment and consumables supplied. Paid back up provided. No community/home based antenatal or labour and birth attendance. Not expected to concurrently run a business. Professional registration and indemnity insurance costs are paid by employer. Supported by organisational systems and processes | $89,000Inherent undervaluation of base salary due to historically female dominated sector and relationship based service+ 3% Kiwisaver employer contribution+ statutory leave or statutory pay+ 30 days annual leave, minimum of 9 days sick leave |
| **Employed core midwife** (MECA price) – 5+ years’ experience | Same qualification and experience. Similar scope of practice. | No on call. Statutory, sick, study leave. Utilises a narrower scope of practice as usually within a ward structure (antenatal, labour or postnatal). Limited autonomy and no caseload responsibilities. Supported by organisational systems and processes. No community/home based care. Not expected to concurrently run a business. Professional registration & indemnity insurance costs are paid by employer.  | $66,755 Inherent undervaluation of base rate due to historically female dominated sector and relationship based service+ 3 % Kiwisaver employer contribution + statutory leave or statutory pay+ 30 days annual leave, minimum of 9 days sick leave+ on call paid separately at $4.04 per hour (currently under negotiation with expectation of 100% increase) |

**Summary of the comparison of remuneration (before business costs and on-call compensation) of roles that share similarities with the work of a community case loading self-employed midwife**

Please note also that in respect of the DHB employed midwife comparators there has been no allowance made to account for any inherent and historical undervaluation due to the gender composition and nature of these roles.

|  |  |
| --- | --- |
|  **Comparison roles $50k $100k $150k**  |  **$200k $250k $300** |
| **Resident Medical Officer (Employed)****GP (Employed)****GP (Contracted)****GP (Self-employed)****Community Midwife (Employed Rural)****Community Midwife (Employed Caseload)****Midwife (Employed Core)****1993 inflation adjusted****1996 inflation adjusted** |  |

**$170k**

**Co-design Recommendation**

**Remuneration only**

 **Remuneration + Benefits**

### Co-design key summary and findings for the pricing methodology

* Two pricing methodologies and seven comparators have been used to estimate fair and reasonable remuneration for a community LMC midwife.
* Both methodologies have limitations in either their comparability to community caseloading midwifery, the additional benefits accrued such as leave, non-contact care/administration, travel, on call, business costs, professional costs, or in the impact of systematic undervaluation due to the historical nature of the work.
* Cost pressure adjustment to the 1993 Maternity Notice results in a price range of $209,000 to $310,700 for 1 FTE.
* Cost pressure adjustment to the 1996 Maternity Payment Schedule results in a price range of $149,260 to $172,755 for 1FTE.
* Fair and reasonable remuneration for 1 FTE (excluding costs and on-call) based on comparable employed workforces results in a price range between $117,400 (Employed DHB Caseloading Midwife MECA adjusted for leave and kiwisaver) and $231,000 (Employed GP adjusted for leave and kiwisaver), before operating costs and compensation of on call expectations.
* The co-design team recommendation for fair and reasonable remuneration 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 is $170,000 per annum for 1 FTE, excluding on call allowance and operating costs.

### Expert statement on strengths and limitations of methodologies in this context

Two pay and remuneration experts were contracted to provide a review of the pricing methodology and outputs of a workshop held with the co-design team in October 2017.

Both agreed that the co-design team had well documented the requirements of LMC midwives, the costs they bear and the potential fees that they are currently paid under various scenarios. The potential for this work to be used as a new framework that recognises the expanded role of midwives and the environments within which they function was acknowledged and the unique role of LMC midwives was highlighted by both parties.

When considering comparator organisations, the experts noted that midwives have been classified as skill group one (the highest skill level) and that one of main stumbling blocks to finding an appropriate comparator for midwives is the unique structure and working conditions of the occupation.

One expert recommended not using commercial job evaluation systems for the LMC midwife context for the following reasons:

* many important aspects of female dominated service jobs are not captured in commercial systems
* there is an intrinsic conflict of interest in that traditional job evaluation providers are not independent and have contracted with the Ministry and broader health sector
* using job evaluation company’s health sector pay data base risks having midwives pay compared with the pay of roles already affected by gender bias.

The second expert considered that an established job evaluation methodology could be of assistance if applied rigorously and working conditions were appropriately, additionally, accounted for.

It was noted that all job evaluation systems are subjective and their use is not a silver bullet but could add understanding to a broader audience as to the core underlying value of the role and its relative position as a healthcare professional.

Based on this advice and the time available, the co-design team did not engage in a formal job evaluation process for LMC midwifery.

The full text of the independent remuneration expert reports are provided in appendix 3.

## Calculation of 1FTE in 2017

The per case price is dependent on the price per FTE and the number of women (cases) that make up 1 FTE.

Historically, NZCOM has recommended a full time case load as being between 40 and 50 women. However, this recommendation was made as early as 1993 when the average complexity was significantly lower due to community midwives taking a smaller (and healthier) proportion of the birthing population. LMC midwives provided care to 40% of the birthing population in 1999, increasing to 77% of all women in 2010 and now 88% of all women giving birth in 2016 register with an LMC midwife.

Community midwifery has historically worked on an ‘overs and unders’ principle, where an individual midwife’s caseload will be a mix of lower and higher need clients, who require less than and more than an ‘average’ amount of time, respectively. Since the inception of the models, as a greater proportion of the population, and in particular, women with complexity that would have previously been under the care of a GP LMC, shared care team or DHB midwifery team, have started to receive LMC midwife care, and an unequal geographic distribution of need has become more pronounced (for example, in 2016, 72% of births in Tairawhiti are to women in the highest deprivation quintile, compared to 7% in of births in Canterbury). This has meant that ‘overs and unders’ no longer functions well at the individual clinician level. This is reflected in population data where we now see that women in high deprivation, Māori & Pacific women, teenagers and women 40 and over are less likely to have a community LMC midwife.

The current Section 88 payment per module does not weight for need with the exception of compensation of additional postnatal visits and some compensation for rural travel. Both these exceptions have tightly prescribed conditions and do not adequately compensate for the associated time and travel involved. Section 88 also has a number of business rules that can result in an inverse weighting of payment to need, due to the requirements for contact by certain points in pregnancy and a strong weighting of payment associated with birth attendance.

As such the co-design team recommends both an adjustment to the average full time caseload, and a new methodology for more fairly remunerating the additional time and travel required by some women and families to achieve equitable outcomes.

To develop a recommendation on appropriate caseloads for 1FTE the co-design group has considered several inputs. These included:

* a consideration of best practice, given the current professional expectations of the role, the content expected to be delivered and the likely needs of straightforward and higher needs clients
* assessment of the results of a workforce survey conducted to inform this work
* assessment of the results of a time and travel tracker application, used 24/7 by a sample of 30 community midwives
* a review of international expectations and evidence.

### Best Practice for a straightforward client

To develop this best practice recommendation for a straightforward client[[6]](#footnote-6) we considered the content and activities required at each contact and the frequency of contact that enables the woman and her family to feel confident and informed about pregnancy, normal birth, breastfeeding, self-care and the care of a new baby. This was tested with the NZCOM professional practice advisors, the Ministry of Health midwifery clinical lead and currently practicing LMC midwives.

|  |
| --- |
| **Best Practice for a straightforward client** |
| **Content and activities required** | **Time** |
| Booking visit @ 60 minutes | 1 hour |
| Minimum 12 antenatal visits @ 45 min each | 9 hours |
| Labour and birth care ranging from 2 – 24 hours (average 8 hours) | 8 hours |
| Immediate postpartum care | 2 hours |
| Minimum 10 postnatal visits @ 60 minutes each | 10 hours |
| Travel – 2 labour, 10 postnatal @ 30 min each | 6 hours |
| Non-contact per client | 12 hours |
| **Total** | **48 hours** |

### Actual time spent by workforce currently – survey data

The co-design team developed a midwife survey, which was undertaken by NZCOM, to get insights into the hours and types of work community midwives are currently doing.

The survey showed the average time respondent’s report per case which summed to 53.0 hours. The survey also showed that midwives were averaging 47.5 clients per year, a total of 2518 hours per year or 1.17 FTE using 2160 hours as full time.

Surveys require recall of retrospective information, and as such are impacted by bias and interpretation, and this survey asked for averages over the previous 12 months. In discussion with NZCOM and midwives, the co-design team consider the data collected through the survey undercounts the time and complexity of the role. This is confirmed by the time tracker data detailed below.

### Actual time spent by workforce currently – time tracker data

NZCOM developed and is piloting a smartphone application-based time tracker tool for midwives to easily account for the contact, non-contact and on-call time they provide. It is in a trial phase currently however early insights show on average midwives are spending 53.25 hours per case, including contact, non-contact and travel but excluding on-call time. The time tracker also showed that midwives were averaging 51 clients per year, a total of 2716 hours per year or 1.26 FTE using 2160 hours as full time.

### International literature on recommended caseloads

Canada has a case loading midwifery model of care and a number of international jurisdictions are actively working to implement this model (UK, Scotland, and Australia). One FTE caseload in these jurisdictions is consistently estimated at 30-40 low need women per annum or around 60 hours per client (based on a 40 hour work week).

### Addressing variable population need for midwifery care

There are a multitude of possible factors that may contribute to pregnant women requiring an additional level of service and time from their LMC midwife.

|  |
| --- |
| **Factors influencing client time requirements for LMC midwives** |
| Medical, psychological or obstetric complexities | * Existing or new medical conditions
* Existing or new mental health issues
* History of obstetric complexity
* Obstetric complexity with current pregnancy or birth
* Obesity complicating pregnancy but below threshold for transfer of care
* Prematurity
* Very unwell baby
 |
| Social complexities | * Unstable housing
* Cold/damp/overcrowded house
* Poverty/material deprivation
* Family Violence/Child Protection
* Alcohol or Drug Abuse
* Smoking
* Unsupported teen
* No family support/isolation
* Previous negative experience of Government services/unwillingness to engage in the ‘system’
 |
| Midwifery complexities | * Miscarriage
* Severe anxiety/fear of birth
* Long labour
* Birth Trauma
* Twins
* Breastfeeding problems
* High risk of SUDI
* First baby
* Rural or remote rural location and travel time
* Central Auckland traffic / parking.
 |

Attempting to capture and model all the potential factors that may require more time from an LMC midwife, over and above the usual time for a straightforward pregnancy, is neither feasible nor accurate.

We propose instead to create a structure where LMC midwives can use their professional judgement to assess the needs and determine which women require the additional time and travel at the individual client level. However, we still need to be able to estimate the service and time required by different levels of need and put audit structures in place.

We have considered a number population health metrics and risk indicators to estimate the level of need, at a population level, for pregnant women who are likely to require more of an LMC’s time. We accept that ‘risk’ does not necessary translate to ‘need’ at an individual level, because some people with multiple risk factors may still not have additional needs or poor outcomes. However, at a population level, cross-referencing a number of risk indicators and analysis for difference sources of data provides us with the best estimate of likely population needs. Some key inputs for this estimate include:

* 30% of pregnant women live in quintile 5 areas (areas that have the most deprived NZDep scores)[[7]](#footnote-7)
* 25% of pregnant women are ‘at risk’ of their children having poor outcomes (Social Investment Agency analysis using cross-agency IDI data)[[8]](#footnote-8)
* 25% have 2-4 risk factors (GUiNZ longitudinal study data)[[9]](#footnote-9)
* 8% of pregnant women have 5 or more risk factors (GUiNZ longitudinal study data).[[10]](#footnote-10)
* 25% of pregnant women are obese[[11]](#footnote-11)
* 15 to 20% of pregnant women are affected by mental health and addiction issues[[12]](#footnote-12), [[13]](#footnote-13)
* 10-15% of pregnant women smoke during pregnancy[[14]](#footnote-14), [[15]](#footnote-15), [[16]](#footnote-16)
* 10% of pregnancies are significantly exposed to alcohol (e.g. through binge drinking)[[17]](#footnote-17), [[18]](#footnote-18), [[19]](#footnote-19)
* 7% of women in New Zealand experience violence during pregnancy[[20]](#footnote-20)
* 5% of pregnancies are teen pregnancies[[21]](#footnote-21) (of which about 90% are unplanned[[22]](#footnote-22)).

Using the above, we estimate that 75% of the New Zealand birthing population could be categorised as ‘straightforward’ from a midwifery perspective. We conservatively estimate that 20% of the birthing population would benefit from some additional care from their LMC midwife, and 5% would benefit from significantly more additional care from their LMC midwife. This is an approximation only and comprehensive data should be captured in the first period of the operation of the funding model to enable refinement over time.

We propose remunerating a base of 48 hours in line with best practice minimums which enables a caseload of 45 straightforward women as 1FTE. It is unlikely however that any midwife will have a caseload comprising 100% of straightforward women. We propose enabling claiming of additional two-hour blocks per client up to a maximum of a further 48 hours (2x the contact, non-contact and travel time) enabling a caseload reduction by up to half to provide the additional time and travel to care for women, while still being remunerated at the level set for 1FTE.

This model averaged across the population and midwives results in an average of 54 hours per case, consistent with the current workforce input and average caseload of 40 women, which is lower than the current average but consistent with the hours per week & year of a full time worker (42 per week/2160 per year).

Further work is needed to model the need for additional time and travel allocation across populations and regions and to build audit and review structures.

### Co-design key summary and findings on calculations of 1 FTE in 2017

* Midwives currently spend on average 54 hours per case
* Midwives currently take on an average of 47 cases a year
* Midwives currently provide on average 2491 hours per year or 1.2FTE per midwife across part time and full time workers
* Averaging across an individual midwife’s ‘overs and unders’ no longer works due to the differential distribution of need across communities and localities.
* Considering minimum care requirements and population need distribution, we recommend setting 1 FTE 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)
* We estimate that 75% of the birthing population is straightforward from a midwifery perspective, and care requirements can be delivered across 48 contact, non-contact and travel hours – enabling a caseload of 45 women
* We estimate 25% of the birthing population has additional need for midwifery care and would benefit from between more midwifery contact, non-contact and travel time across the period from first antenatal registration to postnatal discharge from LMC care.
* We propose a payment structure that enables midwives to claim compensation for extra time spent with women and families who need it. The extra time modules will enable a midwife to reduce her caseload and still receive a full time income when caring for families with additional need.
* Midwives as continuity of care clinicians are best placed to determine a woman/family’s level of need, so all midwives should be eligible to claim additional time blocks. Reporting and audit structures should be put in place to monitor claiming and ensure time is being allocated equitably.

## Calculation of costs of providing community midwifery

**Operating Costs**

**Background**

By virtue of being contracted under Section 88, LMC midwives must cover a number of costs that their employed counterparts are entitled to as a matter of course. The operating costs incurred, other than the direct midwifery care, are not currently acknowledged nor separately funded.

Research has been completed to accumulate actual operating costs from a variety of sources including a sample cross section of current midwives (and their accountants) working in a variety of settings with a variety of women intended to gain a complete understanding of total costs in order to inform the pricing recommendation. The list of costs derived from this research was additionally tested for thoroughness through a Membership survey completed in October 2017. It asserted the completeness of the costs included.

**Current Environment**

* The self-employed contracting funding model supports and strengthens the autonomy of the midwifery profession working in partnership with women
* Section 88 as a modular payment system does not adequately cover all the costs of midwives in New Zealand who operate at the recommended service levels of 40 - 50 women per annum
* Under the current funding model it is the responsibility of the midwives to cover all the costs of providing a primary maternity service to mothers
* Midwives operating costs are predominantly fixed with some variation for caseload and practise setting (rural and Auckland)
* Variable costs represent a small percentage of total costs and include consumables and travel
* Some midwives are currently making decisions that minimise their operating costs. This includes purchasing second-hand or cheap medical equipment as well as relying on generosity of suppliers to not charge them the full market rate.

**Co-design Expectations and Principles**

* In order for fair and reasonable remuneration to be achieved all of these costs must be recognised and paid for in any new funding arrangement.

**Operating Cost Assessment**

|  |  |  |
| --- | --- | --- |
| **All prices are excluding GST** | **Fixed or Variable** | **40 Annual Caseload** |
|  |  | **1 FTE** |
| **Material Costs** |  |   |
| Clinic costs | Fixed |  $ 9,360.00  |
| Home Office | Fixed |  $ 2,000.00  |
| Communication costs | Fixed |  $ 1,500.00  |
| Consumable supplies | Variable |  $ 3,480.00  |
| Vehicle Running Costs | Variable |  $ 9,220.00  |
| Advertising Costs | Fixed |  $ 200.00  |
| **Professional Services Fees** |  |   |
| Practice Management Services | Variable |  $ 1,500.00  |
| Insurances (excluding Indemnity) | Fixed |  $ 500.00  |
| ACC Levies | Step |  $ 1,600.00  |
| Registration with results providers | Fixed |  $ 480.00  |
| Accountant, lawyer and advisors | Step |  $ 1,500.00  |
| Bank Fees and Interest | Fixed |  $ 100.00  |
| GST Cost (If not registered) | Fixed |  $ -  |
| **Professional Costs** |  |   |
| NZ Midwifery Council APC Fee | Fixed |  $ 347.83  |
| NZCOM Subscriptions including Professional Indemnity Insurance | Step |  $ 604.35  |
| Midwifery Standards Review | Fixed |  $ 114.85  |
| Continuing Professional Development  | Fixed |  $ 800.00  |
| **Other Costs** |  |   |
| Other Costs | Mixed |  $ 750.00  |
| Locum Support Payments Made | Fixed |  |
|  |  |   |
| **Fixed Assets** |  |   |
| Vehicle | Fixed |  $ 6,000.00  |
| Office Equipment | Fixed |  $ 400.00  |
| Medical Equipment | Fixed |  $ 900.00  |
| Other: Mobile Phone  | Fixed |  $ 100.00  |
|  |  |  |
|  |  |  **$ 41,457.03**  |

Calculations and any assumptions underlying these figures are set out in appendix 4.

**Comparators**

Ministry of Health Business Cost Calculations (2012) = $40,000 to $45,000 per annum

Public Service per FTE Business Costs = $41,000 per annum

**Co-design Recommendation**

The Co-design team propose that $41,000 per annum per full time equivalent be paid evenly during the course of the year. This we believe would be fair and reasonable payment of the operating costs incurred by midwives.

We recommend pro-rating this payment for lower caseloads but not for caseloads above the recommended 1 FTE proposed per annum. This reduces the incentive for midwives to carry very high caseloads and work at significantly over 1FTE.

We also recommend additional costs should be considered for midwives working in rural areas and in Auckland. An example of additional costs incurred is as follows:

|  |  |  |
| --- | --- | --- |
|  | **Rural** | **Auckland** |
| **Increased Material Costs** |   |   |
| Clinic costs |  $ -  |  $ 4,160.00  |
| Home Office |  $ -  |  $ 500.00  |
| Vehicle Running Costs |  $ 5,220.00  |  $ -  |
| **Increased Professional Costs** |   |   |
| Midwifery Standards Review |  $ 100.00  |  $ -  |
| Continuing Professional Development Fees |  $ 500.00  |  $ -  |
| **Increased Fixed Assets/Infrastructure** |   |   |
| Vehicle Depreciation  |  $ 7,333.33  |  $ -  |
| Other: Mobile Phone or Setup Costs |  $ 100.00  |  $ -  |
|  |  |  |
|  |  **$ 13,253.33**  |  **$ 4,660.00**  |

As mentioned previously how best to ensure coverage and delivery of accessible services in rural and remote rural areas require further review. Early thinking is that these requirements could become part of the scope and responsibility of a national organisation through a national contract.

**Pricing On-Call**

**Background**

On Call responsibilities are necessary and an accepted requirement of New Zealand’s community midwifery model which is centred around providing relationship based (between the midwife and the woman and baby) continuity of care service 24 hours a day 7 days a week.

In considering how midwives should be paid a fair and reasonable amount it is important to consider the following;

* A deep relationship and high level of trust is developed between the midwife and the woman and is constant throughout the pregnancy (from their first meeting until handover to well child provider)
* A woman’s immediate need and access to the midwife can occur at any time day or night and can require physical presence, the answering of a telephone call or replying to a text message. Births in New Zealand occur evenly throughout the day from 12.01am to 11.59pm on any given day. Similarly telephone calls and text messages are received by the midwife at any time of the day and also importantly to note while they are attending other woman.

**Current Environment**

In addition to the increasing population/reducing workforce, and more intense social, and medical complexity there has been creep over time in terms of the functions and responsibilities that midwives have been asked to meet. This has had the impact of increasing the extra time required from the midwife (and as a result indirectly increasing the on call exposure) leading to a genuine deterioration of the quality of life of the midwife and also the midwife’s health, safety and wellbeing.

There are currently no easy solutions available to reduce the amount of on-call responsibility for the midwife while the workforce is diminishing but a fair and reasonable payment would be an immediate positive first step.

**Co-design Expectation and Principles**

* Fair and Responsible remuneration to compensate properly for unusual working hours
* Support Sustainable Workforce including potential to reduce caseload over time and also immediately improve current supply of midwives by attracting non-practising midwives back to the workforce as well providing a medium to longer term solution by attracting more potential graduates into the workforce.

**Comparators**

It is important to note here that the nature of on call and respective responsibilities (although unique and challenging) are an intrinsic part of the continuity of care model and accepted as part of being a community based midwife in New Zealand.

In comparison however to how other health professionals are compensated for on call availability and call outs there are wide variations and it is impossible to accurately identify reflect all variations and related payments.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Comments** | **Available Payments** | **Comparison to Community Midwife** | **Comparative** **Amount** |
| **Prime Service Contract** | Scope includes on call availability and call out to medical related incidents but excludes telephone calls and text messagesCurrent concern from providers that funding does not fairly/accurately fund real costs and in the long term is unsustainable | On Call Allowance $12,000Call out charge per incident  | 75% Prime First Responders have lower probability of actual call out and more ability to manage and roster availability | On Call Availability $12,000Call Out Charge $218based at 1 medical related incident per week @52 weeks) @ 52 weeks$11,336Total $23,336**Adjusted total $31,115** |
| **Core Midwives** | Defined under the current MECA (note in process of being re-negotiated) On call is rostered, managed and limited to ensure standard hours on average per week of 40 hours  | $4.04 per hour on call plus 1.5 for statutory days $6.06 per hour plus hours in lieu to 1.5/2.0 timesUse $4.22 weighted average rateCurrently under review as part of 2017 MECA negotiations | 100% | Total Hours per annum 8760 hours less actual hours where unable to respond Estimated at 25 days per annum at 24 hours = 600 hours On call availability 8160 hoursTotal 8160 hours @ $4.22**$34,435**  |
| **ACC Contracts with Prime Practices** | Injury related responses | Call out attendance fee $183.11 per hour plus travel at $.73 per km | Unknown | Unknown |
| **Registered Medical Officers** | On call is rostered, managed and limited to ensure reasonable standard hours per week in line with contract Call Back includes time from home to place of providing care plus travel | On Call availability allowances from $4 up to $25 per hour Minimum call back and payment 4 hoursLogged telephone conversation 1 hour minimum paymentEmergency on call back up roster $50 per hour | Unknown | Unknown |

**Co-design Recommendation**

The Co Design team propose that $30,000 per annum per full time equivalent paid evenly during the course of the year.

There is outstanding need to assess whether a banding/scaling of this payment is required for lower caseloads but we are agreement that there should be not incentivising of higher caseloads through making additional payments for on call over and above the amount proposed per annum.

Quality Control and Audit assurance would be gained through initial monthly payments being based on projected case loading and then subject to monthly reviews and if required monthly payment adjustments.

**Community Centred Midwifery – National Locum Solution**

**Background**

The Midwifery Workforce is currently under immense pressure with health and safety concerns growing for both women and midwives. This is an unsustainable situation with diminishing midwife numbers and a growing number of women unable to access midwifery care.

As a result of the above comments and also due to the continually increasing scope and requirements of the Community Midwife’s required care (for a number of reasons) their ability to properly arrange and access reasonable leave has diminished.

There is a currently a solution in place for some rural midwives to assist safe resourcing where government funding has been provided to help cover some leave and emergency requirements.

The majority of New Zealand community midwives currently have no other option other than paying for locum cover themselves or accessing their back up (which in turn places more responsibility and risk on that midwife). It also means that midwives are unable to receive the benefit of both the income and the time off which is afforded to most other working New Zealanders.

**Comparison and Calculation**

The co-design team reviewed leave entitlements legally available to similar health workers including both entitlements that accrue (accumulate if not taken or are paid out with a change of employment) or are discretionary entitlements and are taken as required.

These are based on 1 FTE and are to include the following;

|  |  |  |
| --- | --- | --- |
|  | **DHB Core Midwives** | **Registered Medical Officers** |
| Annual Leave | 25 days | 30 days |
| Statutory Leave | 11 days | 11 days |
| Sick Leave | 10 days per annum up to a maximum of 260 days | 30 days and accumulating from Year 4 onwards |
| Shift Leave | 5 days | Unknown |
| Service Leave | 5 days | Unknown |
| Bereavement Leave | At the discretion of the DHB  | At the discretion of the DHB |
| Professional Development Leave and Training/Conferences | 3-5 days | 5-13 days |

Other beneficial leave considerations implicit in the above comparison’s (but not included here) include parental leave (job protection, and paid parental leave), jury service, and allowances including amongst other items Professional Development and Conferences, Uniforms and Protective Clothing, Travelling, Transfer and Relieving payments.

When considering a fair and reasonable leave solution it is important to point out that whilst community midwives are contracted and deemed self-employed they do not have any ability to adjust their market rates (to make allowance for leave entitlements/loading) whereas other self-employed businesses do.

**National Locum Solution Costing**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Comparator****Days** | **Covered by National Locum Service** | **Days left to be managed by Midwife by use of practice arrangements, caseload and leave management)** |
| **Community Midwives** |  |  |  |
| Annual and Statutory  | 36 | 18 | 18 |
| Professional Development | 4 | 2 | 2 |
| Sick and Bereavement Leave/Other Emergency | 10 | 5 | 5 |
| **Total Days to Cover** | 50 | 25 | 25 |
|  |  |  |  |
| **Projected National Locum Funding Requirement**  |  |  |  |
| **Number of required Community Midwives** |  | 1300 |  |
| **Days to be funded per Midwife** |  | 25 |  |
| **Total Days to Fund** |  | 32500 |  |
| **Projected Daily Rate** |  | $700 | (Rate currently utilised under the MOH/NZCOM group rural contract) |
| **Projected National Locum Fund Required** |  | $22.750m |  |

**Co-design Recommendation**

The Co Design team propose that annual funding of $23m is made available so that a National Locum Solution is implemented as a matter of priority to help alleviate the current Midwifery Workforce challenges by attracting back latent supply currently in the general population.

It will also help address in real terms health, wellbeing and safety issues starting to become more frequent and prevalent.

This solution is urgently needed and can be implemented rapidly and would initially follow the rules and parameters of the rural solution that is already operational (including assessment of scaling/banding system). This would also ensure that Reporting, Quality Control and Audit assurance is in place quickly and that potential transitional challenges such as supply and demand matching are assessed and handled in a fair manner ensuring that the quality of the continuity of care is protected.

### Co-design key summary and findings on the costs of providing community midwifery

* Fair and reasonable pay for LMC midwives must cover all costs of providing LMC midwifery including compensation for operating costs and unique on call expectations as well as fair remuneration for time.
* The co-design team recommends explicit compensation of the operating costs of 1FTE LMC midwife at $41,000 per annum
* The co-design team recommends explicit compensation of the on call expectations of 1FTE LMC midwife at $30,000 per annum
* The co-design team recommends these are set as a maximum price per midwife to reduce incentives for very high caseloads/individuals working significantly over 1FTE. We also recommend further consideration of pro-rating this compensation for part time workers.
* A further cost of providing community midwifery is the burden placed on colleagues for cross-cover to enable a midwife to access leave of any type. We recommend an immediate scoping of a national locum service to enable LMC midwives to access fair and reasonable personal and professional leave.

## Summary of the findings of this document

Fair and Reasonable Remuneration $ 170,000

Fair and Reasonable On Call Fee $ 30,000

Fair and Reasonable Overheads $ 41,000

Total funding per 1FTE $ 241,000

1FTE Straightforward Caseload 45 / 75% of population

1FTE Some additional need Caseload 33 / 20% of population

1FTE High additional need Caseload 22.5 / 5% of population

Total FTE required 1,300

Total birthing population served 52,000

Total remuneration costs $ 313,300,000

Workforce Incentives $ 4,000,000

Second midwife and other exceptional costs $ 6,000,000

National Locum Service $ 23,000,000

**Subtotal $ 346,300,000**

Implementation, infrastructure, change management and evaluation (@2%) $ 6,700,000

**Total $ 353,000,000**

## Appendix One: Job Size

|  |
| --- |
| **Job Size: Lead Maternity Carer Midwife** |
| **Consideration** |  | **Role requirements**  |
| **1.0 Purpose of role** | 1.1 Providing midwifery care in a continuity of care model | LMC Midwives provide continuity of care 24 hours a day to pregnant women from early pregnancy to six weeks after the baby is born providing proactive case management over an extended period including:* Antenatal care
* Labour care (conducting normal birth, venepuncture, cannulation, perineal repair, infant resuscitation and newborn examination)
* Postnatal care of mother and baby, contraception and breastfeeding support up to 6 weeks following birth
* Emergency and out of hours care

Manages a full range of pregnancies from straight forward to complex. |
| **2.0 Qualification requirements, on job training, certifications and skills****3.0 Skills required to do the job** | 2.1 Degree required | Bachelor’s degree in Midwifery (3 years or 4800 hours which is equivalent to 4 years of a medical undergraduate degree). Minimum of 45 programmed weeks instead of 28-36 programmed weeks for other degrees.Degree encompasses wide ranging knowledge of social, emotional, physical, cultural aspects of pregnancy, birth and postnatal period. |
| 2.2 On the job training | Graduate midwives must undertake one year of compulsory first year of practice programme (includes attendance at workshops and mentoring). Required to maintain up to date knowledge of practice issues, policies and procedures, government policies and health and social service priorities, and relevant legislative changes.Required to have up to date knowledge of relevant referral pathways, health and social services. |
| 2.3 Certification required | National Midwifery Exam required to become registered. |
| 2.4 Years to test competency | 4-5 years (to experience majority of competency tests). |
| 2.5 Alternative path to Qualification *(note: this is not in addition to the above)* | The average age of graduate midwives is 33 years. Many midwifery students have prior career or degree.Incumbents with a relevant prior qualification (such as other health professional registration) can also gain up to 75 credits as recognition for prior learning. |
| 2.6 Ongoing education and re-certification  | Requirement to complete ongoing professional development and maintain ‘competence to practise’ by meeting the requirements of the Midwifery Council Recertification programme annually. |
| 3.1 Problem solving and complexity | Autonomous practice and decision-making requires drawing on specialised experience and knowledge within Midwifery.Undertakes comprehensive ongoing assessments of women during pregnancy and labour and birth (and of the mother *and* baby postnatally) taking into account physical, psychological, emotional, cultural and social factors.Assesses women who self-refer and may present with a wide range of issues that have not been diagnosed or treated by any other health practitioner. This includes dealing with emergencies. Ongoing risk assessments, management and prioritisation of work scheduling to reflect clinical or health need priorities. Effective time management skills and anticipatory forward planning requirement.Decides appropriate interventions (medical, physical, emotional, social and/or cultural). Diagnoses and prescribes medication and calculates drug doses or treatment plans for a variety of conditions related to pregnancy. Takes/orders blood tests and other diagnostic tests, implements screening programmes (e.g. screening for Downs Syndrome and other fetal abnormalities) interprets results, makes decisions and treats women and babies accordingly.Must explain technical tests and implications in layman’s language; high level of information required for women and families to ensure informed choices and consent.Applies significant judgement and undertakes complex problem solving in managing and determining care requirements.Significant problem solving complexity in emergency situations (especially when off-site and no access to other medical professionals, e.g. home, rural, etc.).Provides care autonomously under own responsibility when pregnancy and birthing experience is normal.Escalates complex medical and mental health (including drug and alcohol abuse) conditions to other specialist medical professionals when needed. However this must be with the agreement of the woman and subject to availability of other medical specialists.When secondary or tertiary care is required, LMCs work with DHB-employed core midwives, the hospital obstetrics team, anaesthetists and paediatricians and frequently continue to provide care. Required to act outside of their scope of practice at times such as emergency situations e.g. haemorrhage, convulsions.Escalates social complex situations to appropriate bodies e.g. family violence.Immediate postnatal care includes assessment of the mother and baby’s physical and emotional well-being, suturing perineal trauma, management of emergencies, directing any secondary/tertiary care referrals, and providing breastfeeding support.  |
|  | 3.2 Interpersonal skills | Interacts and engages with pregnant women in their care, requirement for comprehensive and diverse interpersonal skills and empathy, adaptive, flexible and responsive communication.Ability to develop rapport and engagement quickly and anticipate needs early.Educative and role modelling component to role with women and their families, student midwives and junior midwives.Culturally competent practice and communication skills (midwives provide care to women across all ethnicities and aspects of society).Develops a trusting relationship with women, and acts as a trusted long-term advisor, having a high level of influence over women’s decision making processes. In partnership with women develops and facilitates partner and family information to support women’s decision making.Entrusted to provide advice that women (and her partner/significant family) rely heavily on. Advice may impact on the health of the woman, child or family unit. Provides significant emotional support and advocacy during pregnancy and birth and other stressful emergency situations.Creates working relationships with other midwives, doctors, and a wide range of social agencies and professionals. Provides loss and grief management and support e.g. miscarriage, stillborn, birth defects or adoption.Engages with the woman’s wider family members, typically the woman’s partner and other relatives or significant others who support women around the time of birth (such as mother / mother in law). Makes regular home visits to women.Negotiation and advocacy skills, continues to engage women and other health professionals in constructive relationships when there may be resistance to advice, reluctance to engage with care or conflicting views, while balancing competing priorities to ensure best outcome for women and their babies. |
| 3.3 Physical skills | Required to lift and carry equipment particularly to home visits and attend labours (resuscitation of mother/child, oxygen, sterile materials and birth pool set up etc.).Provides physical support during the labouring process, requiring continual physical effort. Trained in the techniques to provide physical support and care for women during labour. Trained in fine motor skills requiring co-ordination and dexterity to undertake procedures, phlebotomy, venepuncture, cannulation, suturing, vaginal examination, amniotomy, abdominal palpation, new born examination etc.Trained in providing first aid and managing emergencies that may require physical effort.Must be able to drive in all conditions, and maintain equipment.eg change tyres, manage entonox bottles. |
| **4.0 What level of proficiency of the skill is required** | 4.1 Proficiency  | Midwives need to be proficient at all aspects of their role due to the autonomous nature of the work and the context in which it is undertaken (i.e.: midwives practice in community settings such as women’s homes where there is no ready access to other midwives or health professionals for support, second opinion or advice). They also practice in rural settings and secondary or tertiary hospitals where they are frequently expected to manage aspects of complex care, make instant decisions, summon emergency assistance e.g. ambulance, helicopter. |
| **5.0 What responsibilities doe the role have and at what level** | 5.1 Responsibility for health outcomes | Decisions and actions have a positive impact on the pregnancy women and her baby’s health and life outcomes.Being accountable for actions when disability and / or death occur.Remains accountable for outcomes and practice for decisions made by woman or her family. Remains responsible for care when referral to other services is refused.In many rural settings the midwife is the only health professional available and may provide assistance for accident and emergencies in some remote rural areas. |
| 5.2 Responsibility for Services to People | Responsible for working autonomously to provide comprehensive primary maternity services to all women within the midwife’s caseload and to women who call them in labour even if not their LMC.LMC midwives are required to work with a backup midwife or within a small group practice. Midwives will have responsibilities to their back up midwife’s clients (as well as their own) while their back up midwife is unavailable as she is attending one her own clients during labour or during planned leave or scheduled time off call.Required to monitor and report on work outputs and quality. |
| 5.3 Responsibility for People Leadership | Supervises and provides teaching for less senior LMC and core midwives, student midwives and junior doctorsOften seen as having community standing and asked for character references/identification from clients (such as passport witness forms for babies). |
| 5.4 Responsibility for Resources | Management of equipment and supplies.Administration workload.Technology.Financial management of small business skills, required to manage self-employment and owner operator business including planning and scheduling, time management, record keeping, taxation obligations and cash flow requirements.  |
| **6.0 What accountabilities does the job have?** | 6.1 Accountability to women, colleagues, the profession and the public | Accountable for all midwifery care provided to women, through the midwife’s relationship with the women and contractual requirements as set out within Section 88 Primary Maternity Services Notice. Midwifery is a regulated profession so midwives are required to provide care in a competent manner that is to a standard that meets the midwifery competencies as set by the Midwifery Council. The Council also sets the Code of Conduct that midwives professional behaviour is expected to meet. Accountable to colleagues:To provide back up for LMC colleagues as needed.To work collegially with midwives and doctors employed within hospital based maternity services, and any others that the midwife may refer women to for care during pregnancy, labour and birth of the postnatal period. This may include health and social service providers.Accountable to the midwifery profession and wider public:Must meet professional standards of practice and review and report on practice outcomes 2-3 yearly.Not to bring the profession into disrepute, and act appropriately if concerns about care provided by colleagues is noted.Responsible for participating in the education of students and other midwives.Responsible for continuously maintaining and developing practice.To work within all relevant laws and regulations (significant statutory obligations under many Acts) e.g. HPCA, Vulnerable Children’s Act, Contraception and Abortion Act, Misuse of Drugs Act etc. |
| **7.0 What are the working conditions the job is done under?** | 7.1 Working conditions | Required to be available on call 24 / 7 for women in the midwife’s own caseload and her back up colleague’s caseloads (when they are having scheduled time off or are unavailable).Need to be able to re-prioritise / reschedule work at short notice as the nature of labour and birth or emergency attendances is unpredictable. Need to work long and unsociable hours (out of hours and weekends).Required to manage / balance personal and family needs against requirements of case load / on call. Required to be self-employed and run own business / small business management skills. |
| Demands Factor | 7.2 Emotional Demands | Emotionally demanding job involving complex interactions with clients, their families and wider health professionals. Dealing with anxiety of the woman and her family pre, during and post birth, providing emotional support.Dealing with resistance to referral to health and social services.Dealing with demands of attending births at unpredictable hours and working conditions for long periods during the intense emotional and physical experience of birthing.Frequent significant emotional demands; including counselling, grief management, support to women where labour has resulted in poor outcomes or miscarriage has occurred.Medico- legal risks are high as maternity / birth is an area of practice where there is intense scrutiny and high accountability. Clinical actions or omissions have the potential to cause adverse outcomes, or even death in rare instances. Impact on personal life due to significant disruptions in work patterns due to unpredictable nature of work hours and demands and extended periods of being on-call. |
| 7.3 Sensory Demands | Observes and interprets communication with women and her family during pregnancy, labour and birth and the post natal period.Observes and interprets signals and symptoms of women in pain, under stress, and other changing patterns of behaviour during pregnancy and labour.They intuit, question and take action.Prolonged periods of concentration and requirement to move focus of concentration quickly at short notice. |
| 7.4 Physical Demands | Physical aspect of role is a regular feature – daily. Attending women in labour requires physical effort, long hours attendance and physical exertion. |
| 7.5 Working Conditions | Works with hazardous materials, e.g. blood tests, injections, urinary catheters, surgical instruments, placentas, blood, and amniotic fluids.Disposes hazardous materials.Working with clients with issues that may be mentally taxing on the midwife, e.g., mental health issues, drug addiction, family violence, sexual abuse, poverty. |
| 7.6 Place of work | LMC Midwives work in small practices (between 2-8 midwives) both on-site at medical facilities, homes and in the community. Typically midwives would undertake work in a number of locations throughout a working day. Considerable travel is required throughout the working day. |
| 7.7 Typical hours of work | LMC Midwives provide 24/7 coverage for women in their care. Only 31.03% of births occur during standard office hours.Required to attend emergencies or critical events without refusal. Provides coverage/back up to other LMC Midwives both on site and other locations.  |
| 7.8 Volume of Work | Manages a case load of 41 (or more) pregnant women and their families per year -early pregnancy to six weeks after the baby. Visitations and attendance at birthing can be several hours in duration. |
| **8.0 What are the risks? How are they minimised? And who is impacted?** | 8.1 Risks | As a self-employed workforce, midwives are responsible for managing risks associated with their role. The wellbeing of women and their babies is the greatest risk of the role.Other risks include:Midwives personal safety: providing care in the community in women’s homes at all hours, in situations where family violence or other physical threats may be present.Hazardous material risks (as above).Fatigue / on call / work related stress.Managing workload and priorities with women and her colleague’s caseloads. Medico- legal risks are high as maternity / birth is an area of practice where there is intense scrutiny and high accountability. Clinical actions or omissions have the potential to cause adverse outcomes, or even death in rare instances.Work related stress and burn out. Financial risk – dealing with income unpredictability and loss of income due to inability to negotiate terms and conditions of work. |
| **9.0 What is the degree of intensity and frequency of risk?** |  | Degree and frequency of risk is dependent on midwives working situation, geographic isolation, nature of her caseload, working arrangements, media exposure due to high medico legal surveillance (obstetrics is a high complaints area globally) midwives second to GPs for HDC complaints. |
| **10.0 What are the other relevant work features that impact the size or complexity of the work?** |  | Invisible emotional management.Public expectations of a guaranteed live baby.Media scrutiny of the profession.Widespread fear of childbirth driving high anxiety in clientele. |

## Appendix Two: History of significant scope changes

|  |  |
| --- | --- |
| **Year** | **Change or addition in scope of duties** |
| 2002 | Ministry of Health published **Family Violence Intervention Guidelines**, requiring midwives to routinely ask all women about intimate partner violence, and detect child abuse and neglect. |
| 2007 | **Sudden unexpected death in infancy (‘SUDI’).** Ministry issued recommendations for preventing sudden unexpected death in infancy, including requirement for midwives to educate and promote safe sleeping practices with pregnant women, mothers and their families/whānau. |
| 2008 | **Sexually transmitted infections**. Ministry of Health issued Chlamydia Management Guidelines requiringLMC midwives to test pregnant women in their first trimester. |
| 2008 & 2012 | **Mental Health Screening.** In 2008 the Ministry of Health published Identification of common mental disorders and management of depression in primary care. These specify mental health screening requirements in pregnancy and postpartum care. |
| 2012, the Ministry of Health published **Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand** which further set out screening assessment required by LMC midwives. |
| 2009 | **Screening for Down Syndrome and other fetal abnormalities**. Requires offer of first trimester blood test and ultrasound scan or second trimester scan, within a specific time window of pregnancy. Requires complex informed consent discussion, follow-up and possibility of referral |
| 2010 | **Newborn Metabolic Screening**. Updated guidance about the screening process, including timing of procedure. Midwives are responsible for ensuring sample is transported to National Screening laboratory in a timely manner. |
| 2010 | **Newborn hearing screening**. Ministry of Health implemented a national screening programme, requiring midwives to undertake universal offer, informed consent discussion and follow up. |
| 2010 | **Alcohol screening**. Ministry of Health published Alcohol and Pregnancy: A practical guide for health professionals requiring specific screening questions and responses. |
| 2010 | Ministry recommends **universal iodine supplementation** for all pregnant and breastfeeding women, requiring informed consent discussion and prescriptions. |
| 2010 | Ministry recommends **universal recommendation of influenza vaccine** to pregnant women, requiring explanation, education and referral.  |
| 2011 | Introduction of the **Maternity Clinical Information System (MCIS).** Requiring LMC midwives in MCIS DHBs to learn how to use the system. |
| 2012 | Ministry of Health published **Observation of mother and baby in the immediate postnatal period: consensus statements guiding practice.** Requires LMC midwives to ensure women and their babies are not left alone, even for a short period of time in the immediate two hour postnatal period.  |
| 2012 | Government released **Children’s Action Plan**. Increased expectations on detection and response to vulnerable children |
| 2012 | Amendment to 195 of the Crimes Act 1961 requiring **statutory intervention in child abuse or neglect in specific circumstances.** |
| 2013 | Ministry recommends **universal recommendation of pertussis vaccine** to pregnant women, requiring explanation, education and referral |
| 2013 | Ministry of Health released **Companion Statement on Vitamin D and Sun Exposure** in pregnancy and infancy in New Zealand. Requires LMCs to discuss dietary requirements and assess need for supplementation. |
| 2014 | **Gestational Diabetes**. The Ministry of Health published Screening, Diagnosis and Management of Gestational Diabetes in New Zealand: A clinical practice guideline, requiring midwives to offer an additional blood test at booking or registration, weight monitoring and healthy eating advice. |
| 2014 | Ministry of Health published **New Zealand Guidelines for Helping People to Stop Smoking.** Requires midwives to ask women about their smoking status, offer brief advice and refer to a smoking cessation provider. 2015 the Ministry implemented a **maternity smoking target**: 90% of pregnant women who identify as smokers upon registration with a LMC midwife should be offered brief advice and support to quit smoking by the LMC midwife.  |
| 2014 | Ministry of Health published **Guidance for Healthy Weight Gain in Pregnancy**, requiring midwives to calculate pregnant women’s BMI ideally before 10 weeks’ gestation, discuss healthy weight gain, correct folic acid and iodine supplementation and exercise during pregnancy, and monitor weight throughout pregnancy. |
| 2014 | Ministry adds **Rotavirus vaccine to the infant immunisation schedule**, requiring information sharing and education. |
| 2014 | **Misuse of Drugs Regulations** 1977 amended enabling midwives to prescribe the controlled drugs pethidine, morphine and fentanyl (where previously only pethidine could be prescribed), requiring additional education. |
| 2014 | Vulnerable Children’s Act passed, requiring midwives to adopt a **Child Protection Policy and undertake a worker Safety Check.** |
| 2015 | Ministry of Health Chief Medical Officer, issued statement that a **GROW chart** is necessary for an obstetric referral for suspected Small for Gestational Age. Requires access to the software to generate charts, increased ultrasound referrals. |
| 2015 | Ministry of Health issued **Guidelines for verifying death**, specifying that LMC midwives can verify deaths in cases where this was previously a medical responsibility.  |
| 2016 | Ministry published **Taking Action on Fetal Alcohol Spectrum Disorder**: 2016-2019: An Action Plan, requiring specific proscribed screening of all pregnant women for alcohol use. |

## Appendix 3: Expert statements



**Co-design meeting of 11th October**

In last week’s co-design meeting I said I would write some notes on three of the issues that were discussed in the meeting:

* Using commercial job evaluation systems in a pay equity context and specifically in the midwife context
* Using comparator occupations
* Validation – of both job information and job measurement outcomes

**Using commercial JE systems in pay equity processes**

As you know, in 2006 the Government of the day supported the development of a gender neutral job evaluation system that could not only measure female dominated occupations more fairly but was also reflective of contemporary New Zealand organisations and a country that operates in a bicultural and multicultural environment. Equitable Job Evaluation (EJE) was developed by a team of remuneration, job evaluation and pay equity experts and was comprehensively tested and reviewed by overseas and local practitioners. It was not the first system to be developed by the NZ Government. The first, Equity at Work, was developed in 1991 and informed the development of custom built JE systems in the UK in both the Health and Local Government Sectors. I was part of both these developments.

I have attached a copy of the EJE factors and details of what they measure and how they compare with other JE systems. The system is NOT designed to favour female dominated jobs. However, it has utilised research that has identified characteristics of female dominated roles that have been overlooked in the old commercial systems. I have attached some examples.

It is important to stress that EJE aimed to be a job evaluation tool for use in ordinary NZ organisations. It did not aim to turn JE on its head – merely to have a contemporary system to compete with others on the market – and it would have been free! Over time, it would have established a salary database, although the development team did not think this was necessary for its use in the meantime.

Of course, as we know, the Government changed and the project was pulled before it was finalised. It is also important to note that the commercial systems (sensing competition in the government sector) worked hard to discredit EJE. By now, much of the institutional knowledge about the system, its purpose and its structure has been lost. I have personally used the system on many occasions including the completion of the only Pay Investigation in NZ.

The development of the system was in direct response to local and international research and experience of commercial systems not having been designed or operated to fairly reflect the skills, responsibilities and demands of female dominated occupations. These systems have changed little since their development in the 1950’s. Systems have been bought and sold and acquired new names. One of Strategic Pay’s two systems is an old Price Waterhouse Cooper offering.

In fact, many female-dominated roles have not traditionally had their pay set by job evaluation – they are mainly public sector roles where bargaining or funding levels has established pay.

Some years ago I was involved with a pay claim for public service social workers. These jobs had not been sized using JE before. There was an agreement that Hay would be used to size the job. Extensive work was done to obtain good job information and in this case Hay did use the working conditions factor. The outcome was a 10% pay increase for social workers BUT there was a widely held view that many important aspects of this female dominated service job had not been captured by the Hay system and that undervaluation persisted. In my opinion, this is a real risk for a similar evaluation of midwives.

In the UK and in Canada simple custom build measurement systems are developed by independent JE practitioners for pay equity cases.

***NZ JE Standard***

Another important development in the NZ pay equity landscape was the Gender Inclusive Job Evaluation Standard (<https://shop.standards.govt.nz/catalog/8007%3A2006%28NZS%29/view> ) . Australia has since developed their own Standard based on the NZ model.

It was intended that organisations could require their JE providers to meet the standard – and to demonstrate this. In practice, both Strategic Pay and Hay currently simply state that they do meet the Standard. However, there are two aspects to meeting the Standard – firstly, the JE system or measurement tool itself must meet the Standard (and they all now say they do and there is not much that can be done about this since there is a not a moderating service available) but they are also required to meet the standard for EACH JE project.

If JE was to be used as one of the pay information sources for the midwives project, the JE provider must be asked to comply with the Standard. Obviously, part of this will be that they will need to demonstrate how they will measure working conditions and emotional work. They would need to be precise about which of their factor/measures will do this and how this will be weighted. As we know, Hay does not routinely use their optional working conditions factor because this would make the results incompatible with their current data base. This clearly does not meet the NZ Standard.

An important aspect of meeting the Standard is the way in which job data is collected for evaluation purposes and the way in which that data can be measured by the factors. It requires skills and training on the part of the consultant to understand gender and unconscious bias and the way bias is manifested in the design and description of female dominated work. I do not believe that most of the consultants have had training or experience sufficient to meet the requirements of a pay equity exercise.

Job evaluation is not a science. The design of the system reflects societal values of ‘worth’ and in the end measurement judgement can reflect the world view/experience/preconceptions of the evaluator.

Believing that a process is ‘objective’ is not a substitute for designing for gender inclusiveness and for training to minimise unconscious bias.

The co-design team has worked hard to develop a comprehensive description of the midwife role. If job evaluation is to proceed, this and only this, should be the job data that is used. However, it remains a question as to whether the two available JE systems can adequately measure this.

**Other factors**

My other concerns about using traditional JE methodologies to measure the work of midwives are:

* I believe there is an intrinsic conflict of interest – both Strategic Pay and Hay contract with MOH and the broader Health Sector. They are not independent. They (consciously or not) have an imperative to ‘preserve the integrity’ of their salary database and to not challenge some traditional pay relativities. They are also unlikely to want to cut across the interests of their clients.
* As discussed extensively by the co-design group, community midwifery is a unique occupation – in terms of its employment structure, working context, 24/7 on call and travel requirements. These conditions are central to the nature of the work and the way it is carried out. The committee has extensive information on this. Any comparison with other occupations in a standard JE database could only provide a starting point for discussion.
* Using JE company’s health sector pay data base can also risk having midwives pay compared with the pay of roles already affected by gender bias

**Comparator occupations**

In any pay equity exercise (here and overseas) where comparator occupations are required, practitioners such as myself will tell you that selecting comparator occupations is one of the most fraught part of the process. This is particularly true where there is a requirement to (at least initially) seek a comparator in the same sector as the claimants – as in the NZ principles.

In the limited pay equity work that has been done in NZ the Australian and New Zealand Standard Classification of Occupations (ANZSCO) has generally provided a starting point. ANZCO classifies occupations by skill level – for which qualifications are the main proxy. It clusters jobs in main occupation groups and then in sub groups which are more industry or job types linked. It is not linked to actual pay rates.

Midwives are classified as skill group one (the highest skill level). At the health sector level, many of the jobs are also female dominated and are likely (in terms of pay) to be contaminated by the undervaluing of female work. While I have not done the detailed work on analysing the occupations in terms of historical or current gender occupancy, only psychologists or audiologists appear to provide possible comparators.

However, in my experience of processes such as the Pay Investigation for Special Education Support Workers (2007) it has been important to develop some further criteria to assist the selection of comparator occupations. These have included:

* Similar people/care focused work
* Current or historical male occupancy
* Sufficient numbers in the occupation
* Available pay data (often this has been through a collective agreement)
* Willing participants and employers

In my experience of the Special Education Support Workers (SESW) case the selection of comparators (in this case corrections officers and hospital orderlies) also underwent an informal ‘credibility’ test. This is where people’s preconceptions about some male dominated occupations becomes apparent. Some on the project steering group found it completely improbable that SESW could compare themselves to corrections officers (CO) – even though their exposure to the details of the CO was mainly through TV or fiction. Many of the supposed features of CO work simply did not happen in practice and CO work across a range of ‘danger’ settings – from low risk prisons where prisoners went out to work to maximum security. The risks from children biting or hitting or the demands of toileting a teenager (for example) were not imagined as part of the SESW role.

It is also my experience that those people in comparator occupations (and their unions or employee representative) also have difficulty in thinking they can be compared to lower paid female dominated occupations.

However, one of the main stumbling blocks to finding an appropriate comparator for midwives is, as mentioned earlier, the unique structure of the occupation.

**Validation**

After collecting job data and developing the framework for a ‘notional’ job (or two or three) it is important to check that this is broadly understood as an appropriate description. This is generally done by asking a few job holders to check the document and also those that are also in a position to comment – such as managers. This prevents arguments later that the outcome of the evaluation is the result of faulty job data.

When we conducted the SESW pay investigation the jobs were evaluated firstly by using EJE and then another commercial system (Mercer) used the same job data for the claimants and the comparators to evaluate the jobs in their system. This provided good external validation and again anticipated and managed any claim that EJE had provided a biased result. In practice the two systems provided similar results. We were convinced that this was because Mercer were required to use the job information as mandated in the Standard.

**Examples of frequently overlooked job characteristics in work – especially women’s work**

* Knowing emergency procedures when caring for people
* Using a number of computer software and database formats
* Keeping public areas such as waiting rooms and offices organised
* Cultural knowledge
* Dealing with upset, injured, irate, hostile or irrational people
* Operating different types of office, manufacturing, treatment/diagnosis or monitoring equipment
* Manual dexterity in giving injections, typing or graphic arts
* Writing correspondence for others, minute taking, proof-reading and editing other’s work
* Innovating – developing new procedures, solutions or products
* Maintaining manual and automated filing or records management and disposal
* Dispensing medication to patients
* Deciding the context and format of reports and presentations
* Continuous re-ordering and re-prioritising tasks to meet external demands
* Non-verbal communication
* Counselling someone through a crisis
* Gathering and providing information for people at all levels in the organisation
* Concentrating for long periods – computers or manufacturing equipment
* Performing complex sequences of hand eye co-ordination in industrial jobs
* Product quality
* Frequent bending or lifting – including people or children
* Representing the organisation through communication with clients and the public
* Regular light lifting
* Helping to maintain people’s dignity
* Handling complaints
* Managing own response to disgusting situations
* Restricted movement, awkward positions
* Managing cross cultural interactions
* Dealing with death and dying
* Training and orientating new staff
* Exposure to corrosive substances or materials e.g. skin irritations from cleaning
* Shouldering the consequences of errors to the organisation
* Managing petty cash
* Preventing possible damage to equipment
* Co-ordination of schedules for a number of people
* Developing work schedules
* Providing caring and emotional support to individuals (e.g. children or those in institutions)
* Working in production or other noise
* Exposure to disease or unhygienic conditions
* Cleaning offices, stores machinery or hospital wards
* Stress from dealing with complaints (such as child abuse)
* Providing ongoing assessment of people’s needs
* Using emotional empathy
* Being alert to changes in people’s condition

Janice Burns

Top Drawer Consultants

October 10th 2017





## Appendix 4: Details of Business Costs

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| --- | --- | --- | --- | --- |
| **Costs** | **Descriptions** | **Variables** | **Research** | **Notes**  |
| **Material Costs** |  |  |  |  |
| Clinic costs | Location for Antenatal and later Postnatal visits with women. Clinic rooms are generally shared with other midwives or health care professionals. | Caseload will impact the number of days for which the clinic will be rented (1 Full Time Equivalent is calculated at 3 days @ $60 per day) Region (Auckland @$100 per day); Administrator included  | Clinic Rental Searches, Auckland, Wellington and Christchurch as documented | Some midwives look for creative solutions from building their own clinic in their back yard, to converting a shed to sharing with other health care providers who carry the load of the costs. |
| Home Office | Self-employed midwives run their business from their own home and a proportion of their rates, house insurance and power as well as their mortgage interest (but not principal) are considered business expenses.  | Expenses are calculated on the space occupied by the home office, i.e. 10%. This space does not vary with caseload. | IRD Claiming Business Expenses - Using your home for business |  |
| Communication costs | Midwives may use mobile phones, internet, home line phone rentals, answering services and/or pagers in their communications | Midwives can claim 100% of their mobile phone which is generally for business only, 50% of their home rental telephone service as expenses and it is fair and reasonable to also claim 50% of their Internet. Pager and Answering Services are also business related costs. These costs do not vary with caseload. | Standard well known company plans (Vodafone and Spark) | Reliable, quality phones are essential for the running of their business this is especially so for Rural midwives who need to be able to rely on accessing good coverage. |
| Consumable supplies | Consumable supplies vary with caseload and include medical supplies, information for mothers, office supplies and other supplies | Caseload will impact the rate in which consumables are used. | [www.midwifeshop.co.nz](http://www.midwifeshop.co.nz/) | Consumables are often shared with practice partners in order to obtain bulk deals. |
| Travel Costs | This covers vehicle running costs as differentiated from vehicle purchase costs and time spent by the midwife travelling.  | Running costs such as registration and maintenance do not change with caseload. Petrol costs will vary slightly depending on caseload. Rural midwives would be expected to travel further. Urban midwives would be expected to spend more time in their vehicle but this is not covered in this cost. | Only the 2013 Petrol Running Costs were available, 2017 reports are available for purchase to update - http://www.aa.co.nz | Midwives operate from their vehicles and are required to have reliable transport in order to fulfil their requirements. Midwives can claim 100% use of their vehicle for business. Their car is not the family car and contains the equipment and supplies necessary to operate. The on-call nature of their work also requires that their vehicle be available at all times. |
| Advertising Costs | Most midwives are well served by the Find Your Midwife website and are not required to advertise. Practice groups may have website costs (Hosting and Domain Registration) and/or business cards | This does not vary with Caseload |  |  |
| **Professional Services Fees** |  |  |  |  |
| Practice Management Services (MMPO) | In most case midwives are using a payments services provider to claim from Section 88. | This varies with caseload | MMPO |  |
| Insurances (additional to indemnity, vehicle...) | Vehicle insurance costs are included in vehicle running costs, indemnity included with NZCOM membership, medical kit and equipment generally covered in personal household insurance | This does not vary with Caseload | - | One midwife who had suffered a four month loss of income due to health issues some years ago pays for loss of income insurance now |
| ACC Levies | ACC Levies are based on the expected earnings of the midwife in the upcoming year | This varies with income | <https://www.acc.co.nz/for-business/paying-levies/estimate-your-levy/> | Where a midwife is incorporated and pays herself a salary she is required to pay levies both as an individual and a company |
| Registration with results providers | Some DHBS require health professional to pay a monthly fee of over $40 per month for the ability to receive results electronically. | This does not vary with Caseload and is the same regardless of the number of results received. |  | Some midwives are choosing not to subscribe to this service because of the cost and then must spend time on the phone to track down and receive results in a timely manner. |
| Accountant, lawyer and advisors | Accountant costs are the most typical costs in this category | This does not vary with Caseload. |  |  |
| Bank Fees and Interest | Under Section 88 payments do suffer from a delay in payments. | This does not vary with Caseload. |  |  |
| GST Cost (If not registered) | In NZ business are not required to register for GST until they have turnover of more than $60,000 per annum. | This may have an impact for midwives with a smaller caseload but is avoided if they register for GST. | Calculated at 72% of 15% of all costs that are inclusive of GST |  |
| **Professional Costs** |  |  |  |  |
| NZ Midwifery Council APC Fee | Compulsory Practicing Certificate from the NZ Midwifery Council, $400 per annum incl GST | This does not vary with Caseload. | <http://www.midwiferycouncil.health.nz/midwives/practising-certificates/apc-fees> | All these professional costs are covered by DHBS for employed midwives - except NZCOM Membership |
| NZCOM Membership incl Prof Indemnity | NZCOM Membership is not compulsory but offers the cheapest for LMC midwives to obtain Professional Indemnity at $695 per annum incl GST | A 25% discount for low income earners exists | <https://www.midwife.org.nz/join/how-do-i-join-and-what-are-the-fees> | The College have not changed these fees in over 15 years have established robust quality assurance procedures and a unique relationship with QBE Insurance in order to provide this service to members. Individual indemnity insurance would cost well in excess of $2,000 per annum |
| Midwifery Standards Review | Reviews are compulsory every three years with some midwives requested to return earlier if required. $396.25 incl GST | This does not vary with Caseload. This does allow for travel for rural midwives. | <https://www.midwife.org.nz/quality-practice/midwifery-standards-review> |  |
| Continuing Professional Development | Professional Development requirements are set by the NZ Midwifery Council and include 3-5 days per year of education time | This does not vary with Caseload. This does allow for travel for rural midwives. | [http://www.midwiferycouncil.health.nz/sites/default/files/professional-standards/Recertification%20Programme %20March%202017.pdf](http://www.midwiferycouncil.health.nz/sites/default/files/professional-standards/Recertification%20Programme%20%20March%202017.pdf) | This cost solely covers the attendance fee and acknowledges additional travel for rural midwives.  |
| **Other Costs** |  |  |  |  |
| Other Costs | See Co-Design Survey for examples of other costs |  |  |  |
| Locum Support Payments Made | Covered elsewhere |  |  |  |
| **Fixed Assets Depreciation**  |  |  |  |  |
| Vehicle | A vehicle is required to offer midwifery services. It is in business use at all times when a midwife is on-call. As a home-based and often urgent service is expected The vehicle must be reliable. | This does not vary with Caseload. |  |  |
| Office Equipment | Includes a computer and office furniture or other office equipment. | This does not vary with Caseload. |  |  |
| Medical Equipment | Includes fetal monitoring equipment and resuscitation equipment | This does not vary with Caseload. Rural and Homebirth midwives may require a higher standard of equipment. | [www.midwifeshop.co.nz](http://www.midwifeshop.co.nz/) | Midwives currently are not purchasing the highest quality equipment instead looking for ways to save money by buying second hand or cheaper imports. |
| Other:  | In some cases this can include reliable communication devices, setup costs and educational text books. |  |  |  |

1. https://www.nzrda.org.nz/wp-content/uploads/RDA-MECA-searchable.pdf [↑](#footnote-ref-1)
2. https://www.enz.org/salary-general-practitioner.html [↑](#footnote-ref-2)
3. http://m.nzdoctor.co.nz/in-print/2016/march-2016/16-march-2016/up-and-downs-in-earnings-for-gps-on-salary-or-contract-latest-figures-from-mas.aspx [↑](#footnote-ref-3)
4. Personal communication, Deb Pittam [↑](#footnote-ref-4)
5. https://www.midwife.org.nz/meras-meca [↑](#footnote-ref-5)
6. A ‘straightforward client’ is a client without significant complicating medical, obstetric, psychiatric, midwifery or sociocultural needs. [↑](#footnote-ref-6)
7. Ministry of Health. 2017. *Report on Maternity 2015*. Wellington: Ministry of Health. [↑](#footnote-ref-7)
8. A3 paper related to an oral item considered by Social Cabinet Committee: *Social Investment Board Update 01 - at risk mothers and their babies*, on 16 August 2017 (SOC-17-MIN-0132 Minute). [↑](#footnote-ref-8)
9. Morton SMB, Atatoa Carr PE, Grant CC, et al. 2014. Growing Up in New Zealand: A longitudinal study of New Zealand children and their families. Vulnerability Report 1: Exploring the Definition of Vulnerability for Children in their First 1000 Days. Auckland: Growing Up in New Zealand. [↑](#footnote-ref-9)
10. Ibid. [↑](#footnote-ref-10)
11. Ministry of Health. 2017. *Report on Maternity 2015*. Wellington: Ministry of Health. [↑](#footnote-ref-11)
12. Morton SMB, Atatoa Carr PE, Grant CC, et al. 2014. *Growing Up in New Zealand: A longitudinal study of New Zealand children and their families*. Vulnerability Report 1: Exploring the Definition of Vulnerability for Children in their First 1000 Days. Auckland: Growing Up in New Zealand. [↑](#footnote-ref-12)
13. Ministry of Health. 2011. *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Ministry of Health [↑](#footnote-ref-13)
14. National Maternity Monitoring Group. 2013. Annual Report 2013. Wellington. Published in November 2013. [↑](#footnote-ref-14)
15. Morton SMB, Atatoa Carr PE, Grant CC, et al. 2014. *Growing Up in New Zealand: A longitudinal study of New Zealand children and their families*. Vulnerability Report 1: Exploring the Definition of Vulnerability for Children in their First 1000 Days. Auckland: Growing Up in New Zealand. [↑](#footnote-ref-15)
16. Ministry of Health. 2015. *New Zealand Maternity Clinical Indicators 2016*. Wellington: Ministry of Health. [↑](#footnote-ref-16)
17. Ministry of Health. 2015. *Alcohol Use 2012/13: New Zealand Health Survey*. Wellington: Ministry of Health. [↑](#footnote-ref-17)
18. O’Keefe LM et.al. (2015) *Prevalence and predictors of alcohol use during pregnancy: findings from international multicentre cohort studies.* BMJ Open 2015:5. [↑](#footnote-ref-18)
19. Ho R, Jacquemard R (2009). *Maternal alcohol use before and during pregnancy among women in Taranaki, New Zealand*. NZMJ 122(1306). [↑](#footnote-ref-19)
20. Fanslow, Janet, et al. "Violence during pregnancy: Associations with pregnancy intendedness, pregnancy‐related care, and alcohol and tobacco use among a representative sample of New Zealand women." Australian and New Zealand Journal of Obstetrics and Gynaecology 48.4 (2008): 398-404. [↑](#footnote-ref-20)
21. Ministry of Health. 2017. *Report on Maternity 2015*. Wellington: Ministry of Health. [↑](#footnote-ref-21)
22. Growing Up in New Zealand data provided to the Ministry of Health, 2016. [↑](#footnote-ref-22)