Template 1: General Budget Track Initiative Template

This template seeks a high-level summary of the Budget 2018 significant initiatives. Agencies are required to complete the:

- Blue sections for all initiatives (including cost pressures).
- Green sections for cost pressure initiatives.

Your Vote Analyst will complete their assessment in the grey fields. Supporting information must be provided to your Vote Analyst. Please use the descriptions provided as a guide for what information is expected in each of the boxes below.

Contact your Vote Analyst in the first instance with any queries.

Section 1: Overview and Context

<table>
<thead>
<tr>
<th>Vote</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Minister</td>
<td>Hon Dr David Clark</td>
</tr>
<tr>
<td>Initiative title</td>
<td>National Maternity Services - Additional Support</td>
</tr>
<tr>
<td>Initiative description</td>
<td>This funding will provide for the estimated growth in primary maternity claims (driven by increased births and an increase in the number of women using primary community maternity services), increased service delivery costs, and an additional contribution to workforce pressures (‘Lead Maternity Carers’).</td>
</tr>
<tr>
<td>Workstream</td>
<td>Social Sector</td>
</tr>
<tr>
<td>Responsible Vote Analyst</td>
<td></td>
</tr>
</tbody>
</table>

### 1.1 EXECUTIVE SUMMARY

A. Short summary of the proposed initiative and expected outcomes.

The national maternity services cost pressure bid provides $10 million of funding for volume and price pressures for business as usual primary community maternity services. The volume pressures are a result of more babies being born per annum, and more women engaging with community maternity services. The price pressures provide a contribution to increased service delivery costs for primary community maternity services.

This initiative also includes an additional $4 million of funding as a contribution to attract, retain and engage the primary community maternity workforce while further work is undertaken pursuant to the Ministry of Health and New Zealand College of Midwives Settlement (MOH/NZCOM Settlement).

This initiative is expected to result in the following outcomes:

- women, babies and their families, including in rural and hard to staff areas, not losing access to community midwifery services, leading to lower rates of maternal and infant morbidity and in some cases maternal mortality,
- recruitment and retention of the community midwifery workforce and LMCs are better supported to meet professional development obligations, engage in quality improvement activities, support health promotion activities (such as smoking cessation and healthy nutrition) and wider government goals through active linking to other social services.

<table>
<thead>
<tr>
<th>Funding Sought ($m)</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22 &amp; outyears</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating</td>
<td>6.0</td>
<td>14.0</td>
<td>14.0</td>
<td>14.0</td>
<td>14.0</td>
<td>62.0</td>
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<tr>
<td>Operating</td>
<td>-</td>
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</tr>
<tr>
<td>Capital</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Vote Analyst Recommendation</strong></td>
<td><strong>Three components required:</strong> See Vote Analyst Assessment Guidance. 1. [Support in full/Do not support/Partial support and Scale/Defer] 2. [Please provide a two sentence summary to explain your recommended above]. This will be entered into CFISnet and used in the supporting comment next to initiative assessments in advice to Ministers and Panels. 3. [Provide a succinct overall assessment which outlines the key judgements which support your two sentence summary (above)]. This will be used in the Treasury moderation process and package development stages.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree of Government Commitment</td>
<td>[Pre-commitment/manifesto commitment/discretionary]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 2: Problem / Opportunity & Strategic Alignment

2.1 PROBLEM DEFINITION OR OPPORTUNITY

A. Describe the problem or opportunity that this initiative seeks to address.

Initiative

This initiative provides funding of $6 million to manage volume pressures for the estimated growth in maternity claims (driven by increased births and an increase in the number of women using LMC services), $4 million for increased service delivery costs, and $4 million for additional workforce pressures.

Community maternity model

Community maternity in New Zealand is a low cost/high return, internationally recognised, evidence-based service that meets the needs of pregnant women, babies and families in homes and communities. Community maternity increases access to other primary care and prevention services and brokers engagement with social services, reducing overall system cost and supporting good health outcomes and good experience for families. There are positive impacts throughout the life course for two or more individuals per intervention.

Volume pressures

Community maternity providers rely on revenue paid under a schedule in accordance with Section 88 of the NZPHD 2000, which sets out a comprehensive set of fees for service payments for each aspect of primary maternity care, including care prior to the birth (“antenatal care”), during labour and birth, and after the birth (“postnatal care”). There are some supplementary payments for circumstances where providers are likely to incur additional costs (for example, the additional travel costs of providing services in rural communities) or when additional services are likely to be needed (for example, homebirth supplies and support).

The volume pressures are the consequence of the projected increase in the number of Section 88 payment claims due to:

- more births in line with population projections
- more women accessing community maternity services funded under Section 88 (shifted from DHB service provision)
- earlier access to care resulting in higher first and second trimester service volumes
- increased supplementary payments due to increasing clinical and social complexity in the birthing population
- increased access to other services funded under Section 88, including ultrasounds.

<table>
<thead>
<tr>
<th>LMC Volumes</th>
<th>Volume Pressure*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016/17</td>
</tr>
<tr>
<td>First and Second Trimester</td>
<td>59,147</td>
</tr>
<tr>
<td>Third Trimester</td>
<td>54,579</td>
</tr>
<tr>
<td>Labour and Birth</td>
<td>50,220</td>
</tr>
<tr>
<td>Postnatal</td>
<td>53,720</td>
</tr>
<tr>
<td>Rural</td>
<td>20,085</td>
</tr>
<tr>
<td>Ultrasounds</td>
<td>280,100</td>
</tr>
<tr>
<td>Other</td>
<td>11,105</td>
</tr>
<tr>
<td>Total</td>
<td>528,956</td>
</tr>
</tbody>
</table>
*note no volume pressure was provided for in Budget 17. The $6m funding for 17/18 is to provide for the resulting current year volume pressure.

**Price pressures**

The price pressure is designed to compensate community midwives for cost pressures in undertaking business as usual. The table below illustrates the cost of providing a 2.9% increase across all the LMC modules that have been adjusted in previous years (which excludes the price for ultrasounds). The 2.9% is based on Treasury’s labour cost pressure projections.

<table>
<thead>
<tr>
<th>First and Second Trimester</th>
<th>Price Pressures</th>
<th>$0.6m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third Trimester</td>
<td></td>
<td>$0.5m</td>
</tr>
<tr>
<td>Labour and Birth</td>
<td></td>
<td>$1.7m</td>
</tr>
<tr>
<td>Postnatal</td>
<td></td>
<td>$0.9m</td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td>$0.2m</td>
</tr>
<tr>
<td>Ultrasounds</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>$0.1m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$4.0m</strong></td>
</tr>
</tbody>
</table>

**Personnel pressures**

The community midwifery model of care is facing sustainability issues in large part due to current funding and delivery model. The personnel pressures component of this initiative is a contribution to attract, retain and engage the primary community maternity workforce while further work is undertaken pursuant to the MOH/NZCOM Settlement.

**Opportunity**

This initiative is expected to have the biggest impact on the retention and recruitment of the primary community maternity workforce and, therefore, on service coverage; and on workforce morale and engagement. These workforce effects are expected to have an impact on health outcomes, by decreasing the rates of potentially avoidable adverse events. About 16% of perinatal mortality is due to potentially avoidable barriers to access, and 4% to lack of access to antenatal services. The scope for improvement is greater in Maori and Pacific people, who are less likely to use antenatal services in their first trimester, have higher rates of potentially preventable perinatal infant mortality, and are less well represented in the midwifery workforce.

B. What inputs will the preferred option buy and why?

**Inputs:**

- community maternity service coverage for 92 percent of New Zealand women, babies and their families,
- earlier engagement with community midwifery services and
- an increase in the number of ultrasounds being performed,
- a contribution to increased service delivery costs, and
- an additional contribution to workforce pressures.

C. What alternative options were considered and why did you choose your preferred option?

**Alternative options**

*Option 1 – fund cost pressures through reducing community maternity service coverage/timeliness*
Primary community maternity is a core service for pregnant women and infants so any reduction in service coverage is likely to be a cost shifting exercise needing to be picked up by clients (in the form of co-payments), PHOs and DHBs. DHBs are currently funded as the primary maternity provider of last resort and could be expected to cover a higher proportion of the population within this appropriation, but this would have significant impacts on operating budgets in other areas in many DHBs.

Option 2 – fund cost pressures through user co-payments
The New Zealand Maternity Standards require the Ministry to provide access to maternity services at no cost for eligible women. While this requirement does not rule out introduction of co-payments for community maternity services, DHBs would continue to be expected to provide a free primary maternity service and we would expect to see a significant volume shift to their services. This erodes the model of care which seeks to uphold continuity of care and community & home based services and would presents a significant additional cost to DHBs.

Option 3 – fund volumes pressures but not price pressures
Funding price pressures is necessary for recruitment and retention of the primary maternity community workforce and ensuring national service coverage. It is also a component of the MOH/NZCOM settlement.

Preferred option
The decision to submit a cost pressures Budget initiative recognises that the existing community maternity service delivers value for money and is positioned within the health system to deliver a greater Return on Investment than the counterfactual. The alternative options would lead to a more fragmented service that does not align with the international maternity care evidence base or consumer preference; is likely to increase inequity by increasing access barriers and making traversing the system more complex; and increase total system cost due to reduced continuity of care, opportunity for prevention and increased intervention/medicalisation of birth.

D. Counterfactual analysis.
The counterfactual is for the Ministry to manage the cost pressures on an ad hoc basis by variously: maintaining and possibly increasing the current deficit within the appropriation and reducing community maternity service coverage, timeliness and dose. Key implications are:

- loss of current continuity and community midwifery model of care,
- continued exit of skilled and experienced practitioners from the workforce,
- disengaged workforce and reduced contribution to meeting wider health and social sector goals,
- increased rates of in-utero harm as a consequence of reduced support for health promoting activities for example, smoking and poor nutrition,
- increasing workload/cost liability for DHB ‘Provider of Last Resort’ Maternity Services and General Practice,
- increasing lack of access to core health services,
- increase in potentially avoidable adverse events including perinatal and maternal mortality,
- increasing inequity in service access and health outcomes for mothers and babies,
- NZCOM reinstating legal proceedings if the Ministry does not fulfil its commitment to supporting the work of current LMCs, pending further work pursuant to the MOH/NZCOM Settlement.

VOTE ANALYST COMMENT
Has the problem or opportunity been clearly described and does it support a compelling case for investment?
Has the agency clearly outlined what the initiative will be buying, for who (if applicable), and what it is intended to achieve? What is the cost to deliver this proposal and is it comparable to other ‘like’ costs? Has the agency provided detail on the different components making up these costs? Is clear information provided on the alternative options and counterfactual?

If you do not have sufficient information, please follow up with your agency as these are key ingredients for the package development and bilateral advice.

### 2.2 STRATEGIC ALIGNMENT AND COLLABORATION

#### A. How does this initiative fit with your agency’s strategic intentions as outlined in your most recent Statement of Intent, Four Year Plan and Long Term Investment Plans?

**Ministry’s Four Year Plan and Statement of Strategic Intent**

This initiative contributes to one of the six strategic priorities in the Ministry’s Four Year Plan and Statement of Strategic Intent:

- Improve health outcomes for population groups with a focus on Māori, older people and children

As highlighted in both documents, investing well in children earlier can lower costs for the government in the future as they have better health and social outcomes. The system is working with the wider social sector to improve outcomes for New Zealand children. A key aspect of our system is the role of community primary maternity services in supporting young families to have healthy pregnancies and early years which is the focus of this initiative.²

**New Zealand Health Strategy**

This initiative contributes to the Ministry’s strategic direction through alignment with the New Zealand Health Strategy:

- **People-Powered**: it supports pregnant women having choice about their care and receiving continuity of care.
- **Closer to home**: maternity services (excluding labour and birth) are largely delivered in communities and homes

**He Korowai Oranga**

The initiative contributes to He Korowai Oranga with its focus on better supporting high needs populations including Māori and Pacific who are missing out or are not accessing early antenatal care, continuity of care and community based services.

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## 2.2 STRATEGIC ALIGNMENT AND COLLABORATION

### B. Description of engagement with other agencies impacted by this initiative (if applicable).

The Ministry will notify NZCOM in the process of amendment of the Primary Maternity Services Notice that will deliver the personnel cost pressures. Other social service agencies have not yet been engaged in this bid but rely on effective community maternity services as a universal service base and key identification and referral point.

### C. How does this initiative relate to current activity undertaken by your agency and/or by others across the State Sector?

**Strategic alignment**

**Cross-agency** - community maternity is regularly described throughout the social sector as the key universal and acceptable entry point to health and social services. Many universal services such as Well Child Tamariki Ora and the National Immunisation Programme, referred services such as maternal mental health and social services such as Family Start rely on LMCs for the majority of their referrals.

**Health sector** - a strong primary wellness and prevention service for pregnant women that sees them in their communities in the context of their lives and families is essential to support well health, identify health and social needs early and navigate women and families to appropriate services.

## VOTE ANALYST COMMENT

[Please rate this initiative’s alignment with Government priorities on a scale from 0-5]

What strategic intentions [outlined in the Four Year Plan] does this initiative align with?

Is the strategic intent of this initiative clear?

If multiple agencies are involved, is there a clear sense of how the initiative will be delivered collaboratively?

Do they have a clear understanding of how this initiative will fit in with existing activity across the State Sector?

## 2.3 COST PRESSURE INITIATIVE SECTION [IF APPLICABLE]

### A. What are the policy settings and cost drivers creating the pressure or risk?

There is substantial investment in services for pregnant women, children and their families and whānau through universal services, such as primary maternity, general practice and Well Child/Tamariki Ora (WCTO) and early childhood education (ECE) services. Universal services provide families with a basic level of support and a mechanism for early identification of health and social issues requiring intervention or a more specialist response.

The primary maternity system is designed to ensure continuity of care from one health professional responsible for co-ordinating care and referral to appropriate specialists or services as required. Women can choose a Lead Maternity Carer from within their communities and receive antenatal care in a community setting. Primary community midwives work in a partnership model of care with women. In this model each woman and her midwife are partners, working together to ensure that the woman has care that best meets her individual needs.

### B. What are the assumptions underpinning the pressures?

The key assumptions that have been made to establish the cost pressures are as follows:

- the projected number of births for 2018/19 based on StatsNZ projections,
- a price increase of 2.9% (based on the estimated labour cost pressure) has been applied across all LMC modules that have been adjusted in previous years, and
- an additional contribution to workforce pressures (based on the DHB MECA as a proxy).

### C. What options have been identified to address the cost pressures?

Approach to managing cost pressures
The Ministry has received cost pressures funding under Budget 2012, Budget 2016 and Budget 2017 and have increased the fees payable to community midwives by 13% since 2007.

**Option 1 – fund cost pressures through reducing community maternity service coverage/timeliness/dose**

Primary community maternity is a core service for pregnant women and infants so any reduction in service coverage is likely to be a cost shifting exercise needing to be picked up by clients (in the form of co-payments), PHOs and DHBs. DHBs are currently funded as the primary maternity provider of last resort services and could be expected to cover a higher proportion of the population within this appropriation, but this would have significant impacts on operating budgets in other areas in many DHBs.

**Option 2 – fund cost pressures through user co-payments**

The New Zealand Maternity Standards require the Ministry to provide access to maternity services at no cost for eligible women. While this requirement does not rule out introduction of co-payments for community maternity services, DHBs would continue to be expected to provide a free primary maternity service and we would expect to see a significant volume shift to their services. This erodes the model of care which seeks to uphold continuity of care and community & home based services and would presents a significant additional cost to DHBs.

**Option 3 – fund volumes pressures but not price pressures**

Funding price pressures is necessary for recruitment and retention of the primary maternity community workforce and ensuring national service coverage. It is also a component of the MOH/NZCOM settlement.
2.3 COST PRESSURE INITIATIVE SECTION [IF APPLICABLE]

D. What is the efficiency, effectiveness and productivity of this cost pressure area?

Approximately 92 percent of pregnant women make use of primary maternity services.

Providers of primary maternity services must be authorised to claim under the Primary Maternity Services Notice 2007. A provider seeking an authorisation to claim as a lead maternity carer must have an appropriate qualification, professional registration and a current practising certificate. As of July 2018 all existing providers of primary maternity services must also have had the requisite safety check as a core worker under the Vulnerable Children Act 2014.

The Primary Maternity Services Notice details the service specifications under a range of modules of care. For example there are different service specifications for the first and second trimester versus the third trimester. When making claims for primary maternity services, providers must include information indicating that key elements of care for the relevant service module have been carried out (for example the requisite number of client contacts). In addition they must keep clinical records that are accessible for audit purposes to evidence service provision.

Audit is carried out when an abnormal pattern of claiming is detected and/or when there is an issue reported for investigation. Should any failure in standards or safety of service provision, or non-compliant claiming be identified, the matter may be referred to the Midwifery Council of New Zealand. The Midwifery Council of New Zealand has a regulatory role as the guardians of professional standards for midwives in New Zealand. Ministry of Health Audit and Compliance investigates and considers the referral of any significant fraudulent claimants for prosecution.

Please note section 3.4 of this template is also a critical aspect for cost pressure initiatives.

VOTE ANALYST COMMENT

What are the choices around the policy settings and/or where is the requirement specified?
How credible are the assumptions which underpin the identified pressures? How do these compare to the market rates, Statistics NZ data and previous forecasts?
These are critical elements for prioritisation of cost pressures and bilateral advice. Finance Ministers expect to see expect to see better information on the underlying cost drivers, assumptions and impact of these cost and volume pressures.

What actions have been taken to manage or address these pressures (including in previous years) and how credible are the proposed strategic responses?
What is your view on the implications of not funding/partially funding these pressures?
How accurate has the agency been with its previous forecasts?
Advice to Finance Ministers will need to set out how these pressures align with the agency’s medium to long-term strategic direction and the effectiveness of funding provided through previous Budgets.
Section 3: Value for Money and Impacts

3.1 Expected Impacts

A. What are the costs and benefits of this initiative compared to the counterfactual?

<table>
<thead>
<tr>
<th>Impacts – costs and benefits not yet monetized</th>
</tr>
</thead>
<tbody>
<tr>
<td>This initiative provides funding for additional work (volume pressure) and increased income for work done (price pressures). This is expected to reduce the attrition rate among community midwives forecasted in the counterfactual and increase the service coverage rate forecasted in the counterfactual. The impact is that a greater number of women receive care from an LMC of their choice, in their community. The benefit of this is that more women giving birth get care that supports birth as a normal life stage, reducing unnecessary intervention and leading to better birth outcomes. Satisfaction with services is maintained at current levels. The counterfactual is a reduction in coverage due to workforce attrition and lack of funding for additional volumes required due to population growth leading to reduced quality of care, poorer outcomes, increasing inequity and reduced satisfaction from women and families with services and experience. The impact on midwife LMCs is an increase in income and a greater number of clients. The impact on DHBs is prevention of a cost shift as the primary maternity needs of usually resident birthing population continues to be met outside of DHB funding. The impact on wider primary care is reduced demand for urgent pregnancy care from women unable to access a LMC. The impact on women, babies, families and communities is more women and a similar proportion of women as currently can get an LMC in their community that meets their needs. This is expected to have an impact on health outcomes, by decreasing the rates of potentially avoidable adverse events that result from lack of access. About 16% of perinatal mortality is due to potentially avoidable barriers to access, and 4% to lack of access to antenatal services. The scope for improvement is greater in Maori and Pacific people, who are less likely to use antenatal services in their first trimester, have higher rates of potentially preventable perinatal infant mortality, and are less well represented in the midwifery workforce.</td>
</tr>
</tbody>
</table>

Vote Analyst Comment

[Please rate this initiative on a scale from 0-5 to reflect Value for money. Please explain your rating and provide a short comment on the quality of the cost-benefit analysis and the reliability of the inputs. See section 3.2.2 of the guidance.]

Has a compelling counterfactual been provided? Or if not, have the risks and implications been made clear?
The prompts above should be completed at a minimum by the agency to ensure a consistent assessment across initiatives.

3.2 Assumptions and Underlying Evidence

A. Outline the assumptions underpinning the impacts described above.

| A 2.9% fee increase is sufficient to meaningfully reduce midwife LMC attrition. The obstetrician LMC workforce will remain stable without a fee increase due to the ability of obstetrician LMCs to set market price through co-payments. A similar proportion (92%) of pregnant women will access a community LMC if the workforce is sustained. Midwife LMCs will continue to exit the community midwifery workforce at the same or greater rate if no changes are made. Inequalities in access and outcomes for women and babies will continue or increase if no changes are made. Birthing population projections are as per Statistics NZ estimates. |

B. What evidence supports the assumptions and impacts stated in section 3.2.A?

| The midwife community-based, continuity model of care has been widely researched and evaluated internationally and in New Zealand. |
Overall satisfaction with maternity services, LMC services and individual aspects of care are measured nationally by the Ministry of Health every three years, and for each woman who accesses a LMC midwife through the New Zealand College of Midwives. Workforce entry and exit data is collected by the Midwifery Council and reported annually, and is used by Health Workforce New Zealand to undertake comprehensive forecasting.

Population data is supplied by Statistics New Zealand based on best estimates following the most recent Census and has been adjusted to account for the lower than expected number of births in 2016/17.

### VOTE ANALYST COMMENT

Provide an assessment of the assumptions and judgements related to the expected returns. Are these clearly stated and reasonable and appropriate given the proposal's intended outcomes?

Does the evidence (qualitative and/or quantitative) provide reasonable certainty and confidence? Why/why not?

#### 3.3 SENSITIVITY ANALYSIS

**A. Provide examples or scenarios to show how impacts change with different assumptions or policy settings.**

The core assumption is that the level of cost pressure increase proposed is sufficient to sustain the current workforce FTE until changes can be made to the community midwifery funding and payment model.

Should this prove to be incorrect, the projected impacts will not be realised and there will be no or a negative return on investment.

The likelihood of this assumption being incorrect is low due to good engagement of the midwifery sector in the co-design process to develop a new community midwifery funding and payment model.

### VOTE ANALYST COMMENT

Has the agency completed sensitivity analysis which steps through the impact of different elements on the initiative?

This type of information will be critical when outlining choices and impacts/risks associated with trade-offs as the draft package is developed and advice is provided to Finance Ministers.

#### 3.4 FUNDING IMPLICATIONS

**A. Provide option(s) for scaling, phasing and/or deferring this initiative.**

Builds on information provided in section 2.1.B of this template.

The bid set out here is the minimum-level of investment for this initiative. The volume pressures are in line with population projections and current access rates. The cost pressure of 2.9% is the minimum expected to sustain the workforce until the community midwifery funding and payment model can be changed and resourced in line with fair and reasonable remuneration.

The bid has already been scaled in that the cost pressures only apply to selected services provided under Section 88. For example we are not recommending providing any cost pressure relief to obstetrician LMCs or community radiology providers as both are permitted to set co-payment levels.

As per previous years, the Ministry could fund volume pressures but not cost pressures. However this is expected to lead to a significant reduction in the number of midwife LMCs, significant cost shifting to DHBs and significant disruption for women and families. The Government is then likely to face higher downstream system costs to re-recruit enough community midwives to the service.

The Ministry could reduce service entitlements e.g. to limit entitlement to free pregnancy testing in primary care or capping the number of free community ultrasounds. This is unlikely to generate sufficient savings to cover volume and cost pressures, is complex to implement via a Gazetted Notice and is likely to receive backlash from the health sector and consumers.
In addition changes to ultrasounds funded through the Primary Maternity Services Notice 2007 needs to be considered in the context of quality standards for maternal ultrasounds, a process that is yet to begin.

B. Describe the implications on service delivery and risks/trade-offs for each of the scaled, phased or deferred scenarios section 3.4.A.

See the description of the counterfactual for the impact of not progressing the full bid.

VOTE ANALYST COMMENT

Have credible choices and implications been set out? If this initiative is prioritised down or scaled to fit within the draft package, do you have sufficient information to make these judgements? At a minimum, can you provide to Ministers:

- What are the most valuable components
- What is the do-minimum/point at which no worth doing?
- What are the risks or impacts of scaling?

*The development of the Budget package will require trade-offs and prioritisation across initiatives. Advice to Ministers will need to set these choices (and the risks/consequences) out.*
4.1 IMPLEMENTATION AND RISKS

A. How will this initiative be delivered?

Volumes pressures would be managed by MOH Sector Services within usual parameters for processing of claims for primary maternity services from primary maternity service providers. Implementation of the price pressure component would require update of the schedule of fees for primary maternity services under the Primary Maternity Services Notice 2007. This is a regulatory process that requires Ministerial approval of a revised fee schedule in an amendment to the Notice that is then gazetted and presented as a non-parliamentary paper in the House. There is sufficient existing Ministry capacity and capability to implement the initiative in a timely manner.

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Impact or Consequences</th>
<th>Likelihood</th>
<th>Severity</th>
<th>Overall Risk</th>
<th>Mitigation / Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are no risks to delivering this initiative as it is a cost pressure on business as usual</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

**VOTE ANALYST COMMENT**

Please provide a brief comment on the agency’s capability to deliver the initiative and ensure that the expected outcomes are achieved. Has your agency set out the potential barriers or roadblocks expected in implementing the initiative and whether a plan exists to mitigate these? (This could include, for example, limited supply in the market for resources required to deliver the initiative, access to the target population/self-selection issues, and/or ability of agency to contract with providers) [Please rate this initiative red, amber or green according to your assessment of risks associated with the delivery of this initiative. Consider the size of the proposal relative to the agency’s activity, any cross agency impacts, and impacts to front-line service delivery.]

4.2 LEGISLATIVE AND REGULATORY IMPLICATIONS

A. Please detail any legislative implications and whether the Regulatory Impact Assessment (RIA) requirements apply.

Not applicable as is cost pressure on business as usual

**VOTE ANALYST COMMENT**

[Provide an assessment of the regulatory impacts of this proposal in consultation with the Regulatory Quality team.]

4.3 PERFORMANCE MONITORING AND EVALUATION

A. Performance measures/indicators.

This initiative to address volume and personnel cost pressures is expected to maintain the community maternity service while work is progressed pursuant to the MOH/NZCOM Settlement to put community midwifery on a sustainable funding path. The following outcome and output measures will be used to monitor the impacts of the initiative.

**Output measures**

- number and percentage of births receiving community maternity care
- rate of community midwife recruitment and retention
- rate of first trimester registration
### 4.3 PERFORMANCE MONITORING AND EVALUATION

| | • rate of second trimester registration  
| | • rate of primary and home birth  
| | • rate of referral for health services (for example, WCTO, GP)  
| **Outcome measures** | • rate of normal birth/intervention/trauma  
| | • percentage of women giving birth who registered with a LMC in first trimester by ethnic group and deprivation  
| | • satisfaction with maternity services (three yearly survey). |

#### B. Outline how the implementation and performance of the initiative will be regularly monitored.

The initiative will be monitored using data from the existing national maternity data collection. The Ministry provides an annual statistical publication analysing New Zealand maternity services. Consumer satisfaction is measured every three years.  

#### C. Describe the method proposed to evaluate the impact of the initiative [if appropriate].

Not applicable as this initiative is for cost pressures on a business as usual service

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**VOTE ANALYST COMMENT**

Please provide a brief comment on the proposed performance monitoring and evaluation.  
Will it capture the expected outcomes are achieved?  
Is there a clear and quality plan for how the success of the initiative will be measured and at which points or milestones?