

Primary Maternity Services Notice Review 2021

Discussion Document

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Introduction

This document sets out the Ministry of Health's proposed changes to the structure of the *Primary Maternity Services: Notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000* (the Notice).

The Ministry of Health is making these changes to safeguard Aotearoa New Zealand's community-based, continuity-of-care primary maternity model that values women and whānau and their right to holistic, compassionate and individualised care during pregnancy, birth and as new parents.

These changes will:

- increase the flexibility of community maternity services to better meet the varied needs of women and their whānau
- promote equitable distribution of services across the spectrum of whānau needs
- ensure payments correspond better with services delivered
- enable the full application of Budget 2020's new funding for community maternity services
- ensure the scope and types of services funded align with women's needs, the workforces best trained and supported to meet these needs, and with clinical best practice in 2020 and beyond
- ensure the sustainability of community maternity services while decisions on scope and staging of future changes to funding and provision of primary care services are made.

The purpose of this document is to inform community midwives, other providers currently claiming under the Notice, wider maternity and associated health service providers, and women and their whānau about the Ministry's proposed changes to the Notice.

The consultation documents are available on the Ministry's Health Consultation Hub. Feedback can also be submitted any time to section88consultation@thinkplace.co.nz. This and any future iterations of the consultation documents, including the Notice, are working drafts until the final Notice is gazetted.

The Ministry has secured \$21.25 million per annum of new funding under Budget 2020 to resource additional modules under the Notice for midwives caring for women with high needs and women living rurally. There is a further \$10 million per annum of new funding for volume pressures, and a 2.18% increase to selected fee modules applicable from 1 July.

The Ministry intends to gazette changes to the Notice this financial year in order to address pressing issues. This consultation precedes any formal decisions in response to the recommendations of the Health and Disability System Review.

Glossary of terms

Access Agreement means the generic agreement for access to maternity facilities, available on the Ministry of Health website

Additional care means the services provided to women above recognised standard care, in either the antenatal or postnatal period

Additional travel means the portion of travel above 15km one way made by an LMC as part of their job to provide antenatal or postnatal primary maternity care

Antenatal care means the services provided in the period from when a woman has a positive pregnancy test until the start of established labour

Community primary maternity services means the primary maternity services provided in the community to women and whānau, as distinct from primary, secondary or tertiary maternity services provided to women in a DHB setting

Continuity of care means maternity care provided within a philosophy that supports the LMC as the primary provider of care, often provided within a group practice to enable 24/7 service provision

Co-payment means the part charge applicable to services provided by a specialist

District health boards (DHBs) are organisations established by the New Zealand Public Health and Disability Act 2000, responsible for ensuring the provision of health and disability services to populations within a defined geographical area

Labour and birth means the period from the onset of established labour until birth of the placenta

Lead Maternity Carer (LMC) means the care provided by a midwife, general practitioner with a Diploma in Obstetrics or an obstetrician, the aim of which is to provide each woman with continuity of midwifery care throughout pregnancy, labour and birth, and the postnatal period, within a partnership model of care

Local travel means the expected distances an LMC travels as part of their job to provide primary maternity care, defined as up to 15km per one-way trip during the antenatal or postnatal period, or any personal travel during the provision of labour and birth care

Module means a group of services provided by a practitioner for a particular phase of pregnancy, labour and birth, or postnatal period

Non-LMC means a practitioner who is not a woman's registered LMC

Partial module means either the first or last part of a module but not the full module

Primary health organisation (PHO) means a provider contracted by a DHB for the provision of primary health services

Postnatal care means the services provided in the period from two hours after the birth of the placenta until six weeks after the birth

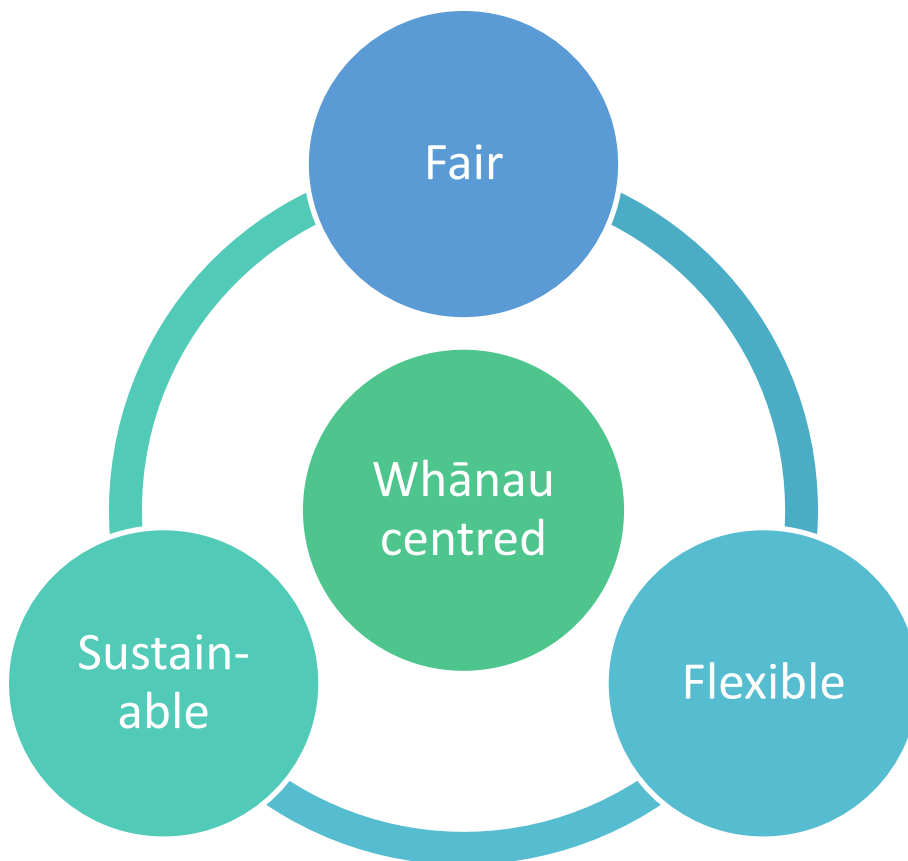
Primary health services means the services specified in the service specifications for essential primary health care services available from the National Service Framework Library

Primary maternity services means the care provided by an LMC, and also by a maternity practitioner who is not the registered LMC

Registration is the process by which a woman selects her LMC, the documentation recording this selection, and the sending of this information to the Ministry of Health

Trimester means the division of a pregnancy into three parts, with the trimester dates being calculated from either the woman's last menstrual period (LMP) or an ultrasound scan

Design principles for the Notice review



Whānau-centred: services are planned and delivered according to what women and whānau need to achieve their best outcomes; there is special recognition of the rights and needs of whānau Māori.

Fair: work done equals work paid.

Flexible: services adapt to meet varying levels of need throughout the maternity journey and the needs of different women and whānau. Services are delivered at times and at locations that work for women and whānau.

Sustainable: timing of payments supports business sustainability. Service specifications support sustainable clinical practice. The overall approach supports the sustainability of community-based continuity of care.

Proposed structure of the Notice

1. First assessment, registration and care planning

1.1 First assessment, registration and care planning

2. LMC antenatal services

2.1 First trimester care

2.2 Second trimester care

2.3 Second trimester pregnancy loss

2.4 Third trimester care

3. LMC labour and birth services

3.1 Labour and birth care

3.2 Home birth planning and supplies

3.3 Planned caesarean attendance

3.4 Labour and birth exceptional circumstances

4. LMC postnatal services

4.1 Postnatal care

5. Primary maternity single services

5.1 First trimester single service

5.2 First trimester pregnancy loss

5.3 Transfer support

5.4 Rural support

5.5 Second midwife services

6. LMC additional travel

6.1 Antenatal additional travel

6.2 Postnatal additional travel

7. Primary maternity ultrasound services

7.1 Ultrasound scans

Proposed administrative changes to the Notice

- Removal of ultrasound reason codes from the Notice (moved to the Ministry of Health's website)
- Removal of Lead Maternity Carer Access Agreement from the Notice (moved to the Ministry's website)
- Updated data recording and reporting requirements in line with HISO Maternity Care Summary Standard 2020
- Updated expectations regarding collection and sharing of health information
- Ending manual claiming and Ministry-hosted online portal claiming

Equity for Māori and the Notice

Māori have the right to experience equitable health outcomes through access to high-quality health and disability services that are timely, safe and culturally responsive to their aspirations and needs. Evidence shows that even when access to services is equal, Māori tend to receive lower-quality care. Equity is an integral component of quality.

Whakamaua: Māori Health Action Plan 2020–2025, p47

For Māori, we acknowledge that pregnancy and birth has unbreakable links to tipuna, whakapapa, whenua and whānau. Maternity services must hold space for mātauranga Māori pregnancy, birth and parenting practice, and uphold mana motuhake for hapū wahine and whānau. Maternity funders must exercise effective kaitiakitanga over maternity services and must hold space for mana whakahaere to ensure services are planned and provided in a way that establishes tino rangatiratanga and upholds tikanga, kaupapa and kawa Māori.

We acknowledge that we must prioritise equity for Māori throughout the review process to ensure the new Notice achieves equity.

The Ministry of Health is committed to fulfilling the special relationship between Māori and the Crown under Te Tiriti o Waitangi. The Ministry, as the kaitiaki of the health and disability system, has the responsibility to enable Māori to exercise authority over their health and wellbeing, and achieve equitable health outcomes for Māori in ways that enable Māori to live, thrive and flourish as Māori.¹

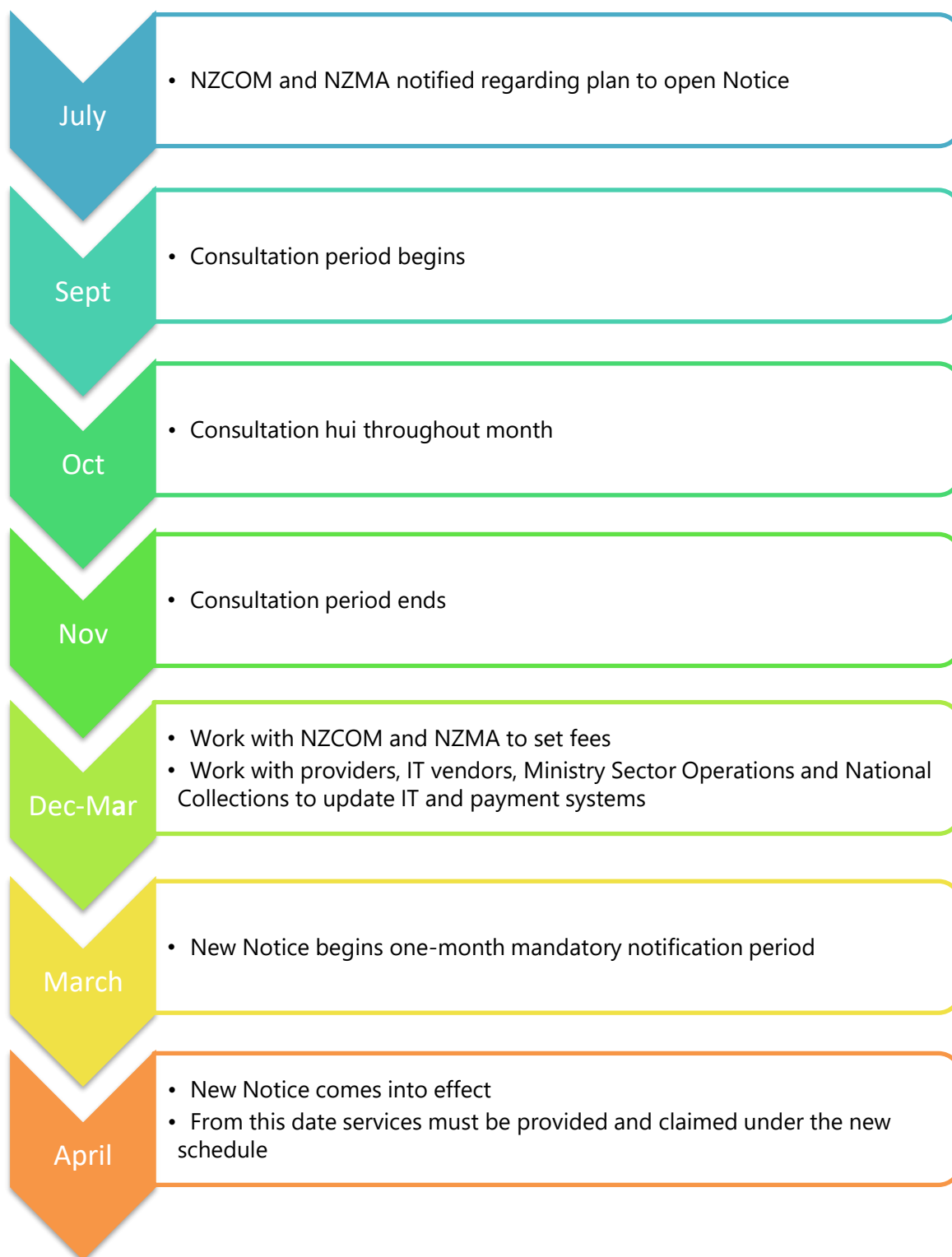
Whakamaua: Māori Health Action Plan 2020–2025 provides a clear direction for the Ministry of Health, DHBs, primary health services whānau, hapū, iwi and other key stakeholders to improve Māori health. The implementation of the plan will be shared and owned across these groups, reflecting the responsibility of all New Zealanders to improve Māori health in Aotearoa.

We acknowledge that there has not yet been engagement with iwi or with Māori maternity sector stakeholders to advise on changes to the Notice that will work to uphold our Tiriti obligations. Therefore, we have deliberately not described changes specific to Māori whānau.

¹ <https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025.pdf>

We will engage iwi and Māori maternity leaders over the consultation period to determine how the Notice can better support community maternity providers as kaitiaki of hapū wahine, pepi and mātauranga Māori pregnancy and birth practice, and what other maternity system changes must be prioritised as part of the Maternity Action Plan to achieve equitable health outcomes for whānau Māori.

Timeline



Detailed description of proposed service and funding model changes

Part 1: First assessment, registration and care planning

Nā tō rourou, nā taku rourou ka ora ai te iwi – With your basket and my basket the people will thrive

Rationale

Registration with a Lead Maternity Carer (LMC) begins the primary maternity continuity-of-care relationship between a woman and her LMC: an intensive relationship that may last upwards of 10 months. Thorough assessment and care planning gives women and whānau information on what to expect and where to seek help, which builds confidence and trust. It also gives LMCs an opportunity for comprehensive screening, education and referrals to support the best possible whānau health and wellbeing.

Proposed change

Under the Notice, the *Registration* module does not currently have a corresponding fee.

Proposal

The Ministry proposes to introduce completion of registration as a fee module, payable on submission of valid registration details.

This recognises the time and work involved in assessment and care planning, and the length of time between start of care and eligibility for the antenatal care fees. This module must be completed before, or on the same date as, the start of LMC care, and delivered as an in-person contact. This contact is not included in the total number of antenatal or postnatal contacts.

The fee for this module can be claimed each time a woman registers with an LMC, unless the new LMC is within the same practice as the original LMC or the woman is re-registering with the same LMC from earlier in the same pregnancy or postnatal period.

Purpose of change

The purpose of this module is to facilitate the development of a partnership between a woman and her whānau and their chosen LMC. It recognises that building a partnership requires time and needs to be tailored to the needs and context of the woman and her whānau. It also recognises the breadth of assessment, screening and education expectations, and non-contact time for referrals and follow up, involved with the first LMC contact, regardless of the stage of pregnancy.

Part 2: Lead Maternity Carer antenatal care

Poipoia te kākano kia puawai – Nurture the seed and it will blossom

Rationale

Antenatal care is universally recognised as important for supporting a healthy pregnancy through the screening and early detection of health and social needs and pregnancy-related complications.² Some women and whānau require brief intermittent contact that increases in frequency as the pregnancy progresses; others require intensive support at times, or throughout the pregnancy, including home visiting for reasons of clinical and/or social complexity. The Perinatal and Maternal Mortality Review Committee recommends that the first antenatal assessment is done before 10 weeks gestation.³ The National Maternity Monitoring Group and Ministry of Health monitor registration with an LMC within the first trimester of pregnancy.⁴

Proposed changes

LMC antenatal care to be split into three trimester modules

The Notice currently splits LMC antenatal care into *First and second trimester* and *Third trimester*. The first and second trimester fee is paid following the end of the second trimester (26th week of pregnancy) and is paid in full for care starting from 17 weeks of pregnancy. This means there is a financial disadvantage for LMCs to begin care before 17 weeks gestation. In 2008, around 50 percent of women giving birth began LMC care in their first trimester. This has now risen to around 74 percent.

Proposal

The Ministry proposes to establish a *First trimester care* module (and fee) that will fund LMCs for services provided in the first trimester of pregnancy. This will remove the financial disadvantage and support more women to receive timely care and support in line with best practice.

The current modules for *Second trimester* care and *Third trimester* care will remain the same, except for the removal of expectations for care during pregnancy loss into a stand-alone module (see below).

² Dixon et al. 2014 <https://www.publish.csiro.au/hc/pdf/hc14279>

³ PMMRC, 2019 <https://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/>

⁴ Ministry of Health, 2019 <https://www.health.govt.nz/our-work/life-stages/maternity-services/national-maternity-monitoring-group>

Partial modules may be claimed by both the outgoing and incoming LMC if a woman changes LMC during the second or third trimester, as long as minimum contact requirements are met. Change of LMC must be accompanied by a new first assessment, registration and care planning module.

LMC antenatal care to include new modules if additional care and support is provided

Currently, the Notice allows for a flat fee regardless of the number or length of contacts provided, or the amount of time spent coordinating care outside of in-person contacts. This disadvantages women and whānau who need a higher level of support and the LMCs who care for them, by establishing a financial disincentive to provide additional time and support. Support needs can vary throughout the antenatal period.

Proposal

The Ministry proposes to introduce three new modules:

- *First trimester – additional care*
- *Second trimester – additional care*
- *Third trimester – additional care.*

LMCs may claim each additional care module, in addition to the standard trimester module when the number of visits exceeds the number specified for standard care. Number of visits per trimester is a proxy measure for additional support provided. We acknowledge that this does not capture additional support in the form of longer visits or non-contact coordination and support. The number of visits is straightforward to measure and is already a reporting requirement. It will not add an administrative burden to LMCs.

We welcome feedback to help determine the best method for allocating additional support funding.

LMC antenatal care to include a new module for second trimester pregnancy loss

Currently, LMC care for women experiencing first trimester pregnancy loss (miscarriage or termination) is not funded separately from first and second trimester care. Care for second trimester pregnancy loss before 20 weeks is not described in the Notice. Women experiencing pregnancy loss, particularly later in the pregnancy, often require additional care beyond the standard second trimester care. This is currently not captured or adequately funded, particularly if pregnancy loss happens before 18 weeks of pregnancy, as only the 'first partial' fee may be claimed.

The new module *Second trimester care – pregnancy loss* will ensure there is no barrier to women receiving responsive and individualised care from their LMC during this difficult time.

Proposal

The Ministry proposes to introduce a new module *First trimester pregnancy loss*.

This will be introduced as a single service module (Part 5) to enable this care to be provided by either the woman's LMC or a non-LMC (midwife or general practitioner) if the woman is not yet registered with an LMC or cannot access her LMC.

Purpose of changes

The purpose of these new modules is to allow LMCs to provide responsive and individualised antenatal care that is scalable to meet additional need either at specific times, such as during pregnancy loss, or across the entire antenatal period.

These changes also allow payments to be distributed throughout the antenatal period (upon registration, upon completion of first trimester, upon completion of second trimester, upon completion of third trimester). This differs from the current Notice which provides minimal compensation until completion of antenatal care.

This is expected to especially support new graduate and new-to-practice LMCs, who currently must cover their set up and service costs for up to five months following registration before becoming eligible for their first payments.

Part 3: Lead Maternity Carer labour and birth care

Ki te whei ao

Ki te ao marama

Tiheiwa mauri ora!

To the glimmer of dawn, to the bright light of day, there is life!

Rationale

For most women and LMCs, labour and birth is the most intensive period of their maternity care relationship. LMC care during labour and birth holds the lives, the health and the experiences of both the mother and baby. Labour and birth is a formative time for women becoming mothers, whānau becoming parents, and for babies entering the world.

The care provided at this time is significant in influencing outcomes and experiences. Responsive and individualised support from a known and trusted health professional during labour and birth has been shown to promote a positive birth experience. It also supports good birth outcomes for the woman and baby. Conversely, the consequences of trauma experienced during labour and birth have lifelong impacts on the whole whānau, affecting bonding, relationships, and mental and physical health.

Proposed changes

Module name changes

Proposal

The Ministry proposes to change the names of the labour and birth attendance modules to distinguish between:

- labour and birth care provided by an LMC midwife (plus their back-up/second midwife)
- labour and birth care provided by an LMC (midwife or doctor) who uses DHB-funded (hospital) midwifery services.

This is in order to provide all required services to a woman and her whānau during labour and birth.

Revised vaginal birth after caesarean section (VBAC) definition

Currently, only women who have had a previous caesarean section and who have never had a vaginal birth are counted as a VBAC for claiming purposes, and an LMC may only claim this labour and birth module if vaginal birth occurs. However, a labouring woman who has a uterine scar from a previous caesarean section requires additional monitoring and support at any subsequent vaginal birth.

Proposals

The Ministry proposes to redefine the VBAC claiming rules to include all pregnant women planning vaginal birth, and who have ever experienced caesarean section.

We also propose to enable this fee to be claimed when the LMC supports a VBAC labour but the woman ultimately gives birth via caesarean section, as additional monitoring and support will have been provided during labour.

Revised Home birth planning and supplies module

The current *Homebirth supplies and support* module requires the LMC to fund both the provision of supplies and a second practitioner to attend the home birth. In practice, paying another midwife from this fee is administratively burdensome and leaves insufficient funding for the additional services and supplies required for a home birth.

Proposals

The Ministry proposes to separately fund a second practitioner through a new single services module – *Second midwife services*. This will enable the second practitioner to claim directly when attending a birth, including a home birth.

We also propose to expand the *Home birth planning and supplies* module to fund an antenatal home visit in the third trimester of pregnancy to develop a comprehensive plan for labour and birth, as well as funding equipment and consumables.

LMCs will still be able to claim this module for a planned home birth when labour begins at home but the woman ultimately transfers to a hospital for the birth.

New Planned caesarean section attendance module

Currently, LMCs attending planned caesarean sections cannot claim a *Labour and birth* fee but can claim a *Labour and birth (exceptional circumstances)* payment.

Proposal

The Ministry proposes to introduce a *Planned caesarean section attendance* module that explicitly funds LMC attendance and support during a planned caesarean section. The new module will enable better data capture and analysis of exceptional circumstances.

Revised Labour and birth exceptional circumstances module

Proposal

The Ministry proposes that this module will now exclude LMC attendance at a planned caesarean section. All claims for this module will have to be submitted in writing and are at the discretion of the Ministry of Health.

Purpose of changes

The purpose of these new modules is to fund an LMC's provision of individualised labour and birth care. Additional funding would be allocated when additional time is likely to be required, such as for a first birth or home birth.

Fairer funding for labour and birth care supports LMCs to uphold the birth choices of women and whānau. It does not create incentives or disincentives that may influence the provision or location of care.

Part 4: Lead Maternity Carer postnatal care

Hapaitia te ara tika pumau ai te rangatiratanga mo nga uri whakatipu – Foster the pathway of knowledge to strength, independence and growth for future generations

Rationale

LMC postnatal care is a unique service that supports both the new mother and her baby, in the context of her whānau, in her own home. Postnatal care supports the transition to an expanded whānau, allows for early diagnosis and treatment of any complications arising for the mother or her baby, supports breastfeeding, provides for contraceptive advice, and links the whānau with other primary health care services such as immunisation.

Currently, postnatal care fees and service expectations differ depending on whether a woman has in-patient care following a birth. If the woman is an in-patient, the LMC is currently required to attend her in hospital for each day she is there. The LMC must be on-call as needed (in addition to the woman and baby receiving care from DHB core midwives) and assist with discharge planning, in addition to hospital discharge planning processes.

This can result in duplication, omissions and confusion regarding the role of the LMC and the DHB. Many women report feeling unsupported during their postnatal hospital stay, and confusion between the role of the DHB and the LMC compounds this. Providing clearer delineation between DHB-funded in-patient postnatal care and LMC postnatal care in the community, alongside supporting DHB postnatal care service improvement through the expanded Maternity Quality and Safety Programme, is expected to result in better postnatal experiences and more support for women and whānau in their homes.

Proposed changes

LMC Postnatal care modules to be simplified

Proposal

The Ministry proposes to set up *Postnatal care* as a single module, regardless of LMC type. The module would specify a minimum number of visits and home visits, alongside service requirements.

In-hospital visits by the LMC can be provided if this is needed. The LMC, woman and the DHB must agree to the responsibilities of the LMC and the DHB, and document in writing who is responsible for in-patient care and discharge planning.

Postnatal home visiting remains the core service in this module. LMCs who currently do not directly provide postnatal home visiting must now arrange this service and pass on this modular payment or arrange a change of registration to an LMC that provides home visiting.

LMC postnatal care to retain additional postnatal visits fee

Proposal

The Ministry does not propose any changes to the current *Postnatal care – additional visits* module.

This module will be continued under the new Notice when the number of visits exceeds the number specified for standard care.

Number of postnatal visits is a proxy measure for additional support provided. We acknowledge that this does not capture additional support in the form of longer visits or non-contact coordination and support. The number of visits is straightforward to measure and is already a reporting requirement. It will not add an administrative burden to LMCs.

We welcome feedback to help determine the best method for allocating additional support funding.

Purpose of changes

The purpose of these new modules is to allow LMCs to provide responsive and individualised postnatal care, in a woman's home, that is scalable to meet additional need. This will provide clearer delineation of the role of DHB in-patient care and the role of an LMC during the postnatal period.

Part 5: Primary maternity single services

Ko koe ki tēnā, ko ahau ki tēnei kīwai o te kete – You at that handle and I at this handle of the basket

Rationale

Non-LMC primary maternity practitioners play an important role in supporting women during pregnancy, birth and the postnatal period. This section revises the scope of services and the practitioner types that may provide these services, to ensure women and LMCs have access to non-LMC services from a range of providers that support the timely and safe provision of LMC care.

Proposed changes

First trimester single services to include midwife providers

The current *Non-LMC first trimester* module is designed to provide pregnancy care and advice and inform women of their options for choosing an LMC. It was introduced when LMCs did not generally provide first trimester care. It recognises the existing relationship many women have with their general practitioner (GP) and aims to support the transition from one care provider to another.

Currently only a GP or midwife working for the PHO practice the woman is enrolled in, may claim for *Non-LMC first trimester* services. In 2018/19 around half of women giving birth received non-LMC first trimester care.

Feedback from GPs has been that the services specified in the current Notice are too onerous and time consuming for the administrative burden of claiming and the amount of payment received. However, many GPs state that they wish to continue seeing women in early pregnancy.

Feedback from LMCs is that this module duplicates the clinical assessments, screening and referrals they usually provide in the first trimester. These assessments often need to be repeated due to inadequate referral processes.

Proposals

The Ministry proposes that the new module *First trimester – single service* will cover only confirmation of pregnancy and support to find an LMC.

We propose to continue this module for GPs. Additionally, we would enable community midwives to be funded for providing this service, for example, at drop-in clinics, to assist in supporting more women to access LMCs early in pregnancy.

The LMC a woman first registers with following this module is not eligible to claim it.

First trimester - pregnancy loss to include LMCs and other midwife providers

The current *Non-LMC first trimester* module includes miscarriage and/or termination care which is designed to provide pregnancy loss care and advice, and arrange termination of pregnancy. It was introduced when LMCs did not generally provide first trimester care.

It recognises the existing relationship many women have with their GP and that the GP is often the first contact for health issues. Currently only a GP or midwife working for the PHO practice the woman is enrolled in may provide care under this module. In 2018/19 around 11,000 women received miscarriage care or termination support from their PHO practice.

Proposal

The Ministry proposes to rename this module *First trimester – pregnancy loss* and expand it to cover care for an actual or imminent miscarriage, or support for accessing a termination, from the provider a woman chooses. This could be her GP, her LMC if she is already registered, a Family Planning service or a drop-in midwifery clinic.

This change recognises the work required to support a woman and her whānau experiencing first trimester pregnancy loss, and that women have the right to support from the provider that they feel most comfortable with at this difficult time.

End to urgent non-LMC care funding under the Notice

Currently, any GP, midwife or obstetrician who is not a woman's LMC can claim fees for one-off urgent pregnancy or postnatal care (as long as the service specification is met), when they provide primary maternity care or facilitate emergency referral to DHB specialist services. Around 30,000 claims for urgent non-LMC care are made each year, the majority carried out during business hours.

Proposal

Under this change, the Ministry will no longer fund urgent non-LMC care. The Ministry considers it the responsibility of the LMC, their back up and practice to provide 24/7 on-call support systems to meet this need. This support should be coordinated with appropriate use of other services such as:

- DHB services in an obstetric or other health emergency
- Healthline for urgent, but not emergency, clinical advice
- the woman's general practice or after-hours clinic for non-pregnancy related urgent health issues.

Women who are out of region and requesting urgent care should be triaged by their LMC, back up or practice over the phone and directed to the most appropriate DHB provider if in-person maternity care is essential.

New module for transfer support

LMC and non-LMC modules currently fund rural obstetric emergency service provision from a midwife or GP and/or rural air or road ambulance transfer costs to the practitioner who accompanies the woman and/or baby.

Proposal

The Ministry proposes to split these services as they are distinct and carry different costs.

We propose to introduce a new module: *Transfer support*.

This module could be claimed by any practitioner, including the LMC, who accompanies a woman and/or baby from a community setting via air or road ambulance to a base hospital. It is intended to cover the costs of the practitioner returning to their home or vehicle.

We also propose that this module covers any air or road ambulance transfer during pregnancy or the postnatal period, not just during labour and birth.

Revised rural support module

Proposal

The Ministry proposes to introduce a revised *Rural support* module that funds urgent care and treatment from a GP or midwife who is not the LMC to support an LMC in a rural area. This does not include transfer support.

New module for second midwife services

In 2017, NZCOM negotiated a payment for community midwives who support LMCs at home births and in other birth situations that require a second practitioner for clinical safety or support. This is currently administered through a workaround in the Notice, repurposing a non-LMC rural support claim code.

Proposal

The Ministry proposes to introduce a new module: *Second midwife services*.

This dedicated module will support better data collection and increase awareness of the funding available when second midwife support is required.

Purpose of changes

The purpose of changes to single service modules is to better correlate work with fees, and clarify the scope and potential providers of services delivered in support of LMC care.

Part 6: Lead Maternity Carer travel

Kia mau ki te tokanga nui a noho – There is no place like home

Rationale

Travel is both an expected part of their role and a significant business expense for LMCs. Most postnatal care is provided in women's homes, and many LMCs provide some in-home antenatal care, including early labour assessment and support. LMCs also travel to attend births at homes and DHB facilities, and may travel to accompany women to specialist clinics and other appointments when required.

While a degree of local travel is part of routine LMC care for all women, and is compensated through module fees, additional travel funding is not distributed fairly and does not always cover the costs or time involved. Inequitable funding for additional LMC travel disadvantages women who would benefit from additional home visiting, including antenatal home visiting and support to remain at home in early labour, and disadvantages LMCs who work in rural communities or congested urban areas.

Fair compensation of actual costs incurred travelling to women's homes to provide LMC care is fundamental to achieving equity for all women and whānau, regardless of where they live.

Proposed changes

Currently, only rural postnatal travel is funded, and the fees are allocated based on the address of the woman at LMC registration, using rural/urban classifications that were last updated in 1993. These codes are no longer accurate, due to urbanisation and population growth over the last 27 years. These classifications indicate that 36 percent of women receiving LMC postnatal care reside in rural areas, compared to current Statistics New Zealand data which shows that 14 percent of the total population resides rurally. The current Notice uses three categories based on these 1993 rural area unit codes (semi-rural, rural and remote rural) with different levels of funding available for each classification.

The more significant problem with the current approach is that it doesn't correlate well with actual additional travel requirements. For example, the lower funding level for women living in semi-rural areas underfunds the LMC who travels from an urban area if there are no local LMCs available. Additionally, the higher funding level for women living in remote rural areas overfunds an LMC who lives near a client.

Proposal

The Ministry proposes to introduce a new funding approach for LMC travel. The *LMC additional travel* module would fund travel per kilometre, over a specified minimum threshold per trip (15km one way).

We acknowledge the burden this places on LMCs to collect data for trips 15km and over, and on IT vendors to report travel data to enable these payments. However, we consider this to be the most equitable and transparent approach to meeting the actual costs incurred in delivering home-based care when additional travel is required.

The module would apply to travel 15km or over to and from antenatal (including early labour) and postnatal home visits. It would also apply to travel for antenatal or postnatal visits provided in other locations as required by the woman and her whānau.

This model would exclude travel from the LMC's home to their clinic, and travel to a home or hospital birth as these standard costs are built into module fees. While most travel costs are incurred by LMCs providing care to rural clients, this module will support any LMC travelling distances of 15km or over to deliver care in homes and communities.

Purpose of changes

The purpose of this change is to support LMCs in postnatal visits to women in their homes. It also covers other situations where home visiting is of benefit due to additional clinical or social need by fairly funding the costs of travel beyond standard practice.

Part 7: Ultrasound scans

Rationale

Community ultrasound providers are currently funded per scan to deliver routine screening (nuchal translucency scanning for early evaluation of chromosomal abnormality at 11 to 13 weeks, and fetal anatomy and placental position at 18 to 20 weeks). Other ultrasound scans may be needed for urgent or ongoing suspected fetal and maternal problems, such as suspected fetal growth abnormality, suspected ectopic pregnancy, bleeding in pregnancy and reduced fetal movements.

The number of ultrasound scans per woman has increased significantly since the introduction of the Notice, from an average of 2.6 scans per woman giving birth in 2007/08 to 4.9 scans per woman giving birth in 2018/19. Community ultrasounds generally attract a co-payment, which means there can be a financial barrier to accessing this service.

Proposed changes

More work is required to identify the most effective way to purchase timely and equitable primary maternity ultrasounds. This must include consideration of co-payments and equity, consideration of the quantity and reasons for community ultrasounds, and consideration of the role of DHBs, both as secondary and tertiary maternity service providers, and as required by the Service Coverage Schedule to ensure women have access at no cost to primary referred ultrasound services.⁵

Proposal

The Ministry does not propose any changes to ultrasound services.

We propose to remove the Ultrasound Reason Codes from the Notice and make them available on the Ministry's website.

This will enable changes to be made to the schedule of ultrasounds without formally opening the Notice.

Any proposed changes will be discussed with the relevant professional colleges and will reflect the recommendations from the of the Maternity Ultrasound Advisory Group (MUAG), which were endorsed by the National Maternity Monitoring Group in 2017.

Purpose of change

The purpose of this change is to enable easier introduction of future changes to the provision and purchasing of community ultrasound services. Review of primary maternity ultrasound indications and implementation of other MUAG recommendations is a programme under the *Maternity Action Plan* to be completed by 2023.

⁵ <https://nsfl.health.govt.nz/accountability/service-coverage-schedule/service-coverage-schedule-202021>

Part 8: Specialist Services

Rationale

A small number of private obstetricians and paediatricians provide specialist consultations to women and babies under the Notice. These are funded per consultation through the Notice although specialist medical maternity service providers may choose to charge a co-payment.

Women can be referred for consulting obstetrician services by a GP, midwife, another obstetrician or a family planning practitioner. Last year around 1000 obstetric consultation claims were paid under the Notice. DHBs may not claim under the Notice for consulting obstetrician services.

Babies can be referred for consulting paediatrician services by their LMC or back-up LMC. Last year around 5000 paediatric consultations were paid under the Notice. DHBs may not claim under the Notice for consulting paediatrician services.

Proposed changes

National purchasing of specialist medical maternity services in the form of consulting obstetrician or paediatrician services does not fit in a primary maternity services specification. The Ministry proposes these services should be removed from the Notice.

The vast majority of women and babies who need care from an obstetrician or paediatrician receive this from their DHB, funded through Population Based Funding. DHBs currently provide over 150,000 outpatient maternity consultations per year, including around 45,000 obstetric consults and provide nearly 80,000 outpatient consultations to infants under one per year, including around 13,000 paediatric medical and surgical consults.

The Ministry is undertaking analysis of the distribution of specialist medical maternity service claims and will work with any DHB expecting to receive significant additional volumes of obstetrician or paediatrician referrals to help manage this transition.

Proposal

The Ministry proposes removing Consulting Obstetrician Services and Consulting Paediatrician Services from the Notice.

Purpose of changes

The purpose of this change is to ensure the Notice remains a mechanism for nationally funding primary maternity services. This change also ensures a standard referral pathway (through DHBs) for all women and babies who require specialist care.

Appendix 1 – Fee schedule mapping

Proposed new	Mapping to current Notice
First assessment, registration and care planning	
First assessment, registration and care planning	Registration (unpaid)
LMC antenatal care	
First trimester care	New
First trimester care – additional care	New
Second trimester care – full module	Replaces LMC first and second trimester services
Second trimester care – first partial	Replaces LMC first and second trimester first partial services
Second trimester care – last partial	Replaces LMC first & second trimester last partial services
Second trimester care – additional care	New
Second trimester care – pregnancy loss	New
Third trimester care – full module	Replaces LMC third trimester services
Third trimester care – first partial	Replaces LMC third trimester first partial services
Third trimester care – last partial	Replaces LMC third trimester last partial services
Third trimester care – additional care	New
LMC labour and birth care	
LMC first birth	Replaces LMC labour and birth services first birth
LMC VBAC	Replaces LMC labour and birth services VBAC
LMC subsequent birth	Replaces LMC labour and birth services subsequent birth
Hospital midwifery first birth	Replaces LMC labour and birth services first birth if a GP/Obs has used hospital midwifery services
Hospital midwifery VBAC	Replaces LMC labour and birth services VBAC if a GP/Obs has used hospital midwifery services
Hospital midwifery subsequent birth	Replaces LMC labour and birth services subsequent birth if a GP/Obs has used hospital midwifery services
Home birth planning and supplies	Replaces home birth supplies and services
Planned caesarean attendance	New
Labour and birth exceptional circumstances	Replaces labour and birth exceptional circumstances

Proposed new	Mapping to current Notice
LMC postnatal care	
Postnatal care – full	Replaces LMC services following birth
Postnatal care – first partial	
Postnatal care – last partial	
Postnatal care – additional care	
LMC additional travel	
Antenatal additional travel Postnatal additional travel	Replaces semi-rural/rural/remote rural postnatal full/postnatal first partial/postnatal last partial
Primary maternity single services	
First trimester single service	Replaces non-LMC first trimester services without threatened miscarriage, miscarriage or termination
First trimester pregnancy loss	Replaces non-LMC first trimester services with threatened miscarriage, miscarriage or termination
Transfer support	Replaces Non-LMC labour and birth (rural support)
Rural support	Replaces Non-LMC labour and birth (rural support)
Second midwife services	Replaces Second midwife support, claimed as Non-LMC labour and birth (rural support)
Primary maternity ultrasound	
Ultrasound	Replaces maternity radiology specialist consult
Not mapped to new Notice	Maternity obstetrician specialist consult, maternity paediatrician specialist consult, non-LMC urgent normal hours, non-LMC urgent out of hours, non-LMC urgent postnatal, labour and birth birthing unit

Appendix 2 – Time points and minimum contacts for proposed fee modules

Fee	Service start date	Service end date	Minimum visits to be eligible for fee
First assessment, registration and care planning	Positive pregnancy test	5 weeks 6 days from date of birth	1
First trimester	Positive pregnancy test	13 weeks 6 days	1
First trimester additional	Positive pregnancy test	13 weeks 6 days	3 or more during first trimester
Second trimester	14 weeks 0 days	27 weeks 6 days	3
Second trimester additional	14 weeks 0 days	27 weeks 6 days	5 or more during second trimester
Second trimester first partial	14 weeks 0 days	19 weeks 6 days	1
Second trimester last partial	20 weeks 0 days	27 weeks 6 days	2
Second trimester pregnancy loss	14 weeks 0 days	19 weeks 6 days	1
Third trimester	28 weeks 0 days	Onset of established labour	5
Third trimester additional	28 weeks 0 days	Onset of established labour	10 or more during third trimester
Third trimester first partial	28 weeks 0 days	33 weeks 6 days	2
Third trimester last partial	34 weeks 0 days	Onset of established labour	3
Antenatal additional travel	Positive pregnancy test	Onset of established labour	1km

Fee	Service start date	Service end date	Minimum visits to be eligible for fee
Labour and birth	Onset of established labour	2 hours following birth of placenta	1
Homebirth planning and supplies	28 weeks 0d	2 hours following birth of placenta	1 (home)
Planned caesarean attendance	Day of planned caesarean attendance	2 hours post-operative	1
Labour and birth (exceptional circumstances)	Onset of established labour	2 hours following birth of placenta	1
Postnatal	2 hours following birth of placenta	5 weeks 6 days from date of birth	7 with a minimum of 5 at home
Postnatal additional	2 hours following birth of placenta	5 weeks 6 days from date of birth	11 with a minimum of 5 at home
Postnatal first partial	2 hours following birth of placenta	2 weeks 6 days from date of birth	4
Postnatal last partial	3w 0d from date of birth	5 weeks 6d from date of birth	3
Postnatal additional travel	2 hours following birth of placenta	5 weeks 6 days from date of birth	1km
First trimester single service	Positive pregnancy test	13 weeks 6 days	1
First trimester pregnancy loss	Positive pregnancy test	13 weeks 6 days	1
Transfer support	Positive pregnancy test	5 weeks 6 days from date of birth	1
Rural support	Positive pregnancy test	5 weeks 6 days from date of birth	1
Second midwife services	Onset of established labour	2 hours following birth of placenta	1