Introduction: Seeking feedback on the Discussion Document and draft Notice

# Introduction

This consultation sets out the Ministry of Health’s proposed changes to 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 flexibility of community maternity services to better meet the variable needs of women and their whānau
* promote equity by driving a fairer distribution of services across the spectrum of whānau need
* ensure payments correspond better with services delivered
* enable the full application of Budget 2020’s new funding for community maternity
* ensure the scope and types of services funded align with women’s needs, the workforces best trained and supported to meet these needs and ensure alignment 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 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, should be read as working drafts until the final Notice is gazetted.

## SURVEY SECTIONS

## Part 1 First Assessment, Registration and Care Planning

## Part 2 Lead Maternity Carer Antenatal Care

## Part 3 Lead Maternity Carer Labour and Birth Care

## Part 4 Lead Maternity Carer Postnatal Care

## Part 5 Primary Maternity Single Services

## Part 6 Lead Maternity Carer Travel

## Part 7 Ultrasound Services

## Part 8 Specialist Services

# Design principles for the Notice

**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.

# Equity for Māori and the Notice

For Māori, we acknowledge that pregnancy and birth has unbreakable links to tupuna, 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.

*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.

# Your background

Knowing about you helps us make sense of the feedback you leave with us. Please tick which of the following applies to you.

* Profession

[ ] Self-employed midwife providing LMC services

[ ] Private obstetrician providing LMC services

[ ] Private obstetrician providing specialist consulting services

[ ] Private paediatrician providing specialist consulting services

[ ] General practitioner providing LMC services

[ ] General practitioner providing non-LMC services

[ ] DHB-employed midwife

[ ] DHB-employed doctor

[ ] DHB management

[ ] Other (please state)

* Ethnicity

[ ]  New Zealand European

[ ]  Māori

[ ]  Samoan

[ ]  Cook Island Māori

[ ]  Tongan

[ ]  Niuean

[ ]  Chinese

[ ]  Indian

[ ]  Other (please state)

* Is your work predominantly with women and whānau who:

[ ]  Live in an urban setting

[ ]  Live in a rural setting

[ ]  Are Māori

[ ]  Are Pasifika

[ ]  Other (please state)

* Do you **currently** claim from the Section 88 Notice for providing primary maternity services?

[ ]  **YES** **[ ]  NO**

# Detailed description of proposed service and funding model changes

## Part 1: First Assessment, Registration and Care Planning

### 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, completion of registration currently does not have a corresponding fee.

***NEW LMC first assessment and registration fee [new DA18]***

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.

Q1. Do you agree that this is a module that would benefit from funding? [ ]  **Yes** **[ ]  No**

**Comments Box**

## Part 2: Lead Maternity Carer Antenatal Care

### 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. 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. The National Maternity Monitoring Group and Ministry of Health monitor registration with an LMC within the first trimester of pregnancy.

### Proposed changes

***NEW LMC antenatal care to be split into three trimester modules [new DA20/24/31]***

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.

***NEW LMC first trimester module [new DA20]***

The Ministry proposes to establish a new *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 Part 5 of this survey).

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.

***NEW LMC antenatal care to include payments for additional care [new DA22/27/34]***

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.

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.

***NEW LMC antenatal care to include a module for second trimester pregnancy loss [new DA30]***

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.

***NEW LMC antenatal care to include a module for first trimester pregnancy loss [new DB9]***

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.

Q1. Do you agree that splitting the payments for antenatal care into three modules will support business sustainability? [ ]  **Yes [ ]  No**

**Comments Box**

Q2. Do you think it is warranted to compensate LMCs for the time and care they provide when a woman has a second trimester miscarriage or termination of pregnancy? [ ]  **Yes [ ]  No**

**Comments Box**

## Part 3: Lead Maternity Carer Labour and Birth Care

### 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

***REVISED Module names [new DA36/40/42]***

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 [new p17]***

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.

The Ministry proposes to redefine the claiming rules around VBAC to include all pregnant women planning vaginal birth 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 [new DA38]***

The current *Homebirth supplies and services* 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.

The Ministry proposes to separately fund a second practitioner through a new single service module – *Second midwife services* (see Part 5 of this survey). 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 or birthing unit for the birth.

***NEW Planned caesarean section attendance module [new DA40]***

Currently, LMCs attending planned caesarean sections cannot claim a labour and birth fee but can claim a labour and birth exceptional circumstances payment.

The Ministry proposes to introduce a *Planned caesarean 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 [new DA42]***

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.

Q1. We are proposing changing the definition of VBAC to mean a vaginal birth for a woman who has had a previous birth by caesarean section, whether or not she has also had previous vaginal births Do you agree with this change? [ ]  **Yes [ ]  No**

**Comments Box**

Q2. Do you agree with separating Labour and Birth (exceptional circumstances) from attendance at a planned caesarean section? [ ]  **Yes [ ]  No**

**Comments Box**

## Part 4: Lead Maternity Carer Postnatal Care

### 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

***REVISED LMC Postnatal care modules [new DA44]***

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.

***RETAIN LMC postnatal care- additional visits fee [new DA46]***

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

### 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.

Q1. Do you agree with the simplification of the postnatal care modules? [ ]  **Yes [ ]  No**

**Comments Box**

## Part 5: Primary Maternity Single Services

### Rationale

Non-LMC primary maternity providers 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

The current *Non-LMC first trimester care* 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 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.

***NEW First trimester single services to include midwife providers [new DB7]***

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.

***NEW First trimester - pregnancy loss to include LMCs and midwife providers [new DB9]***

The current *Non-LMC first trimester miscarriage and termination care* 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.

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 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.

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 will be triaged by their LMC, back up or practice over the phone and directed to the most appropriate DHB provider if face-to-face maternity care is essential.

***NEW Transfer support module [new DB11]***

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. The Ministry proposes to split these services as they are distinct and carry different costs. We also propose to introduce a new module: *Transfer support*.

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

We also propose that it will cover any air or road ambulance transfer during pregnancy or the postnatal period, not just during labour and birth.

***REVISED Rural support module [new DB13]***

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 Second midwife services module [new DB15]***

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.

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.

Q1. Do you agree that midwives, as well as general practitioners, should be able to provide and claim for primary maternity single services? [ ]  **Yes [ ]  No**

**Comments Box**

Q2. Do you agree with the scope of the services to be provided in the transfer support module?

[ ]  **Yes [ ]  No**

**Comments Box**

Q3. Do you agree that midwife providers should be compensated for providing first trimester care to a woman experiencing a miscarriage or termination? [ ]  **Yes [ ]  No**

**Comments Box**

Q4. Do you agree that following any air or road transfer with a woman or baby, practitioners should be compensated for the cost incurred for return travel? [ ]  **Yes [ ]  No**

**Comments Box**

Q5. Do you agree with the new scope of second midwife services? [ ]  **Yes [ ]  No**

**Comments Box**

## Part 6: Lead Maternity Carer Travel

### 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 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 shoes 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.

***NEW LMC additional travel modules [new DC4/6]***

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.

Q1. Do you agree with the proposed methodology for funding additional travel? [ ]  **Yes [ ]  No**

**Comments Box**

## Part 7: Ultrasound Services

### 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.

***RETAIN Ultrasound services***

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.

Q1. Do you agree with removing the ultrasound codes and having them available on the Ministry website? [ ]  **Yes [ ]  No**

**Comments Box**

## 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.

***END Consulting obstetrician and paediatrician modules [old DC12/14]***

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.

Q1. Do you agree with the proposed exit from consulting obstetrician services? [ ]  **Yes [ ]  No**

**Comments Box**

Q2. Do you agree with the proposed exit from consulting paediatrician services? [ ]  **Yes [ ]  No**

**Comments Box**

# We would like to ask you about the future of maternity services in Aotearoa New Zealand

Q1. If you could choose three ways to invest time and/or money into maternity services, what would they be?

**Comments Box**

**1.**

2.

3.

Q2. What else would you like us to know?

**Comments Box**

Q3. If you be willing to be contacted for a follow up conversation about the future of maternity services please leave your email address below:

Thanks for your feedback.

You can return feedback forms to us via email: section88consultation@thinkplace.co.nz

or Post:

Section 88 Consultation

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