New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

3 November 2020

ThinkPlace Limited
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Wellington 6041

By email: section88consultation@thinkplace.co.nz

Section 88 Consultation – Primary Maternity Services Notice

Dear Sir/Madam

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above consultation. The NZMA is New Zealand's largest medical organisation, with more than 5,000 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. We recognise the principles of te Tiriti o Waitangi and the special obligations to Māori, particularly to ensure equity and active protection. Current disparities in health outcomes between Māori and non-Māori are unacceptable. The NZMA is committed to advocating for policies in health and the social and wider determinants of health that urgently address these disparities and contribute to equity of health outcomes. Our submission has been informed by feedback from our Board, Advisory Councils and members.

1. The NZMA welcomes the review of the Primary Maternity Services Notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 (the Notice). The existing model of funding for maternity services has needed addressing for years. As a party to the Notice, we were disappointed at not being consulted by the Ministry of Health prior to the development and circulation of the draft new Notice. However, we understand that the draft Notice dated September 2020 is intended as an early working draft to help elicit feedback, and that changes to the wording in the draft Notice are expected following consultation. We welcomed the opportunity to provide preliminary feedback to ThinkPlace Limited and the Ministry via a Zoom videoconference on 6 October. We reiterate many of the points raised during the 6 October meeting in this written submission which takes the form of general comments on the review followed by specific comments relating to particular clauses in the draft Notice. We note that the NZMA is to be involved in consultations to set the fee schedule under the Notice and we seek further information about the approach to these consultations.

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General Comments

2. The draft new Notice appears to be very midwifery focussed. Yet maternity care entails more than that provided by the LMC midwife. Our view is that the proposed draft new Notice runs the risk of neglecting the important role of non LMCs in maternity care. This is a retrograde step and does not provide for the convenience of the woman or give her choice. Worryingly, the direction of the draft new Notice appears to signal the Government pulling out of funding free universal maternity care with serious implications for equity and access. For example, there is no funding for any non LMC care other than one simple antenatal visit and pregnancy loss visits. We believe that key principles which should underpin maternity care in New Zealand include choice and convenience of access, equity, promoting teamwork and collaborative care, and an integrated approach to antenatal care.

3. We note that the Ministry is proposing to no longer fund urgent non-LMC care. Instead, 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. The NZMA has serious concerns with this proposal, given that around 30,000 claims for urgent non-LMC care are made each year. We do not believe this will work in practice and we are unable to see how this proposal will benefit women. It does not provide for the convenience of the woman or give her choice, key principles that should underpin maternity care. The proposed changes also do not provide information as to how a pregnant woman who is not registered with an LMC can access urgent care. It also does not address if a woman chooses to see her GP or attend a local after-hours clinic and does not call her LMC. We contend that there needs to be a return to a fee for service model for non-LMC antenatal care on the grounds of access, equity and choice for pregnant patients in primary care.

4. There are a range of issues arising from, or exacerbated by, pregnancy for which women go to their GPs. These include threatened miscarriage, morning sickness, treated hypothyroidism (needing medication adjustments), hypertension (needing medication changes or adjustments) and mental illness. We seek clarification on how non-LMC urgent care is to be funded given that capitation for General Practice does not cover such services.[1] Is the Ministry's expectation that women pay full fees for such consultations or will General Practice be allowed to charge the LMC?

5. There is a well-recognised shortage of midwives in many parts of the country, particularly in rural areas. Midwives are often difficult to get hold of in a timely fashion in an emergency. Many women cannot easily find a LMC and there are often delays in seeing them. As such, many women are only seen in the second trimester. The DHBs only offer backup services and don't have the capacity to see every urgent pregnancy case who cannot get hold of their LMC.

6. We are particularly concerned at the implications of the proposed changes on maternal mental health. Midwives are not trained to assess the severity of, or to treat, mental health conditions such as anxiety or depression. This is a core area of work for GPs. This is recognised by the fact that under the Section 88 Referral Guidelines, women presenting with these conditions during pregnancy are to be referred to their GP. Furthermore, many secondary maternal mental health services will not accept referrals from LMC midwives, only GPs. The most recent report of the PMMRC stated that *"Pregnancy and the postpartum period are not protective against mental illness, and can be a trigger for onset and for deterioration of mental illness. Suicide is a leading cause of maternal mortality, with Māori women and young women (20 years old) over-represented among maternal suicides… All clinicians involved in a woman's care need relevant mental health history and current knowledge of a woman's pregnancy to support them to provide*

[1] PHO Services Agreement Schedule C2 Part C Section 10. Available from www.shorturl.at/cgY02

the best care. Routine sharing of relevant information across general practice, LMC and mental health service interfaces will enable better-informed care, and any concerns regarding risk need to be clearly communicated to all clinicians involved." Rather than creating a further barrier to care as the proposed changes do, we believe there should be greater support for involvement of GP input for any woman experiencing mental health issues during her pregnancy, whether that is an urgent or non-urgent need. All mental health input by a GP for a pregnant woman should be free for the woman and readily accessible.

7. We note that wording in the draft new Notice appears to require consultations to be in-person visits in order to be eligible for funding. For example, proposals relating to new modules for LMC antenatal care refer to "minimum in-person contact" and "number of visits per trimester" while also acknowledging time spent during "non-contact coordination and support". We believe the updated Notice needs to enable consultations to take place via telehealth where this is appropriate.[2] As the situation following COVID-19 showed, many consultations can be done safely and appropriately via telehealth, particularly during the first trimester. Accordingly, we ask the Ministry to ensure wording in the draft Notice allows for funded consultations via telehealth where appropriate.

8. The draft Notice remains weak in encouraging information sharing and communication between midwives and GPs. Too often, patients are referred to their GP by their midwife with no information. This is dangerous care. We understand that many midwives also still rely on paper-based information systems which are not conducive to promoting good linkages and shareable documentation. Funding arrangements should encourage note keeping systems that are capable of integration with other record systems in Primary and Secondary Care and therefore support informational continuity of care.

9. We believe that there are strong grounds to fund a 6-week postnatal consultation for the mother. When mothers bring their baby for the 6-week vaccinations / check, the mother often has issues that need exploring with their GP. The four common areas are mental health, contraception, feeding issues and pelvic floor problems. The 15-minute appointment is very busy as the GP is meeting the baby for the first time, doing the full 6-week check if it hasn't been done before, and checking baby is well enough for vaccinations. Furthermore, the documentation GPs receive regarding the birth is very basic and generally does not address the mother's medical issues. The handover process is very poor and is an area in which there is considerable room for improvement to promote continuity of care.

10. If there is a reluctance to return to a fee for service model for non-LMC maternity services, we suggest consideration be given to a separate funded maternity stream for non-LMC consultations under the maternity contract that recognises the reality of service provision and availability of GPs as opposed to midwives. This could acknowledge pregnancy loss, pregnancy confirmation, other medical issues including mental health, and postnatal care. In particular, provision needs to be made for women to be able to access funded GP care for mental health issues.

11. With respect to ultrasound services, despite additional scanning, PMMRC reports do not indicate a subsequent improvement in outcomes. In addition, some ultrasound providers appear unable to complete an anatomy scan at one appointment so there is a second or even third appointment, for each of which the LMC is expected to provide a further referral and for which,

[2] Telehealth and Remote Consultation. NZMA Position Statement. September 2020. Available from https://bit.ly/357Auk8

no doubt, an additional fee is claimed. It is suggested the Notice would better meet the needs of women by the following:

- Restricting the number of scans after 20 weeks unless authorised by a consultant obstetrician for a stated clinical reason
- Each requested scan being completed for a single fee irrespective of the number of scans required
- Setting the fee payable on the same basis as capitation for GPs as the deprivation scaling should improve equity of access.

Specific Comments on Primary Maternity Services Notice (September 2020 Draft)

Page 12, B1, (1) (b) (viii)
We note that termination of pregnancy is not covered under the definition of primary maternity services. We seek clarification on how termination will be funded given that it will be provided in primary care by GPs. Will women be expected to pay for this?

Page 13, B1, (1) (b) (xiii)
We seek clarification on what this clause means.

Page 13, B5
We ask whether the Access Agreement is being updated? We believe it should be updated with regard to complying with clinical protocols within the DHB facility. Currently, a source of friction exists between practitioners not employed by DHBs coming in to the hospital and not following DHB overall guidelines and/or not joining in with reviews of poor outcomes, for example.

We seek clarification about facilities for medical termination of pregnancy

Page 14, established labour
The definition of established labour is vague and unhelpful. Not all women in labour have frequent, painful, strong contractions. It would be better to use a measure of cervical dilation such as when vaginal examination shows the cervix to be at least 3cm dilated. While not a perfect definition, this would be more consistent.

Page 15, home birth
We ask whether this clause covers the unplanned home birth?

Page 15, hospital midwifery services
If every LMC has a suitable backup, we query whether this is necessary?

Page 15, last menstrual period (LMP) date
We suggest this should just be the known date of the LMP. Back calculations (as happen at present) to enable completion of the MoH form are dangerous and unnecessary. Clause CC3 does not require it to be provided for a claim to be accepted.

Page 16, on call
We believe it would be useful to clarify what being available by phone or pager to provide telephone advice means. For example, would a text message response or the use of AI to provide advice suffice, or is the practitioner expected to be available to respond by voice?

Page 16, Referral Guidelines
We would like to know when the Guidelines for Consultation with Obstetric and Related Specialist Medical Services are going to be reviewed.

Page 17, secondary maternity services, (b)
There are a range of views on how ultrasound scanning is divided across primary and secondary care. There is a sense that the present system works against DHBs providing this service. It is important to view ultrasound scanning through an equity lens as despite additional scanning, some people are still missing out on fundamental scans. In paragraph 11 of this submission, we have suggested how the Notice could better meet the needs of women.

Page 23, CB3, (1) (c)
We note this clause states that a maternity provider must ensure that primary maternity services they provide are provided by sufficient numbers of suitably skilled and qualified practitioners. We ask what happens if an LMC has a greater caseload than their College advises, or if there are not sufficient LMCs in an area to provide care for the women. This clause doesn't acknowledge the issue of the maldistribution of the workforce.

Page 23, CB4
We ask for clarification on what is meant by Māori health outcomes. If these are not specified, then this is a meaningless phrase.

Page 24, CB10
This clause relates to a maternity provider having systems and processes for ongoing improvement of the quality of primary maternity services that they provide. We suggest this should include taking a full part in DHB review processes and providing information for PMMR, for example. This would make it consistent with clause CB9.

Page 25, CB12, (2)
Our understanding is that this clause, by definition, requires practitioners to comply with the requirements of the local PMMR coordinator to provide documentation when asked.

Page 27, CC5, (5)(a)
The claim form must be in a format that can be saved (unlike the current Notification of Abortion form).

Page 29, DA1, (1)
This should be about the whole of maternity care, not just lead maternity care or midwifery. As such, we suggest changing "the aim of lead maternity care" to "the aim of maternity care" and changing "continuity of midwifery care" to "continuity of care". Some women do not want midwifery care and make their feelings about it very clear. The current system and what is being proposed doesn't allow for women wanting a mix of GP and private obstetrician care.

Page 29 DA2 (1)
We prefer the term medical practitioner to 'relevantly qualified doctor'. As such, we suggest rewording this clause to refer to registering with "a midwife or medical practitioner of her choice".

Page 31 DA6 (1)(c)(iii)
This clause notes that the LMC is responsible for all care required during the first 6 weeks following birth. Our view is that this is impractical, especially when urgent care is needed.

Page 32 DA7 (8)
We suggest the insertion of 'timely' to this clause such that it reads "An LMC is responsible for ensuring that timely referral to primary health services and Well Child services is offered".

Page 32 DA8 (3)
This clause states that if clinical responsibility for a woman's care transfers to a secondary maternity service or tertiary maternity services, the woman's LMC midwife may continue to provide midwifery care to the woman in collaboration with the DHB services. We seek clarification on how this is to be decided as well as what practical value it bring.

Page 33 DA9 (3)
This clause refers to a transfer of care from the LMC to the Well Child provider that meets the guidelines agreed by the New Zealand College of Midwives and providers or Well Child Services. We would like to know where these guidelines are published. We also believe that non midwife LMCs should be involved in these guidelines.

Page 33 DA10 (2)
This clause refers to guidelines agreed by the New Zealand College of Midwives and the Royal New Zealand College of General Practitioners. We would like to know where these guidelines are published.

Page 37 DA20 (2) (b)(ii)
This clause needs to be updated to reflect the guidelines and latest amendment to the Abortion Act. In due course, midwives will be able to provide early medical abortion and also surgical termination of pregnancy in the first trimester if suitably trained and in a formal service. The same applies to GPs.

Page 39 DA39(1)
The payment for home birth planning and supplies should also be payable for unplanned home birth as the LMC will have used the equipment (frequently carried in the LMC's car).

Page 44, DA 40 (1)(a)
This clause relates to LMC attendance at a planned caesarean section where requested by the woman and where the LMC has provided third trimester car. We seek clarification on the purpose of funding this when the woman will now be under secondary care.

Page 51 DB15
It is inappropriate to specify that second carer services only apply to midwives. For example, in certain regions, LMCs may call upon one of the local GPs to be the second carer at the birth. Accordingly, we ask for the wording in this section to be amended so that it applies to other practitioners as well as midwives.

We hope our feedback is helpful and look forward to the opportunity to review a revised version of the draft Notice prior to its finalisation.

Yours sincerely

K. Baddock

Dr Kate Baddock
NZMA Chair