13/11/2020 SM20-133

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Tēnā koe

Draft Primary Maternity Services Notice (Section 88)

Thank you for giving The Royal New Zealand College of General Practitioners (the College) the opportunity to comment on the Draft Primary Maternity Services Notice (Section 88).

We are New Zealand's largest medical college with a membership of more than 5,500 GPs. We advocate for equity, access, and sustainable healthcare and believe fundamentally that regardless of who or where they are, every New Zealander should have access to their own GP.

The College is the post-graduate training organisation for doctors wanting to specialise in general practice. Right now, 871 doctors are training to be GPs in our General Practice Education Programme (GPEP) which covers clinical and practical education and takes around three years.

We also set and assess quality standards for general practices and administer the ongoing professional development programme our members need to complete every year to maintain their practising certificates.

Other College functions include research, assessment, communication, representation, and advocacy. College Fellows also provide advice and expertise to government and the wider health sector. The Division of Rural Hospital Medicine is a separate, but related, Fellowship which comes under the auspices of the College.

We are making our submission in addition to the meeting held on 11 November and would be keen to further discussion any issues raised here.

We hope you find our submission helpful. If you have any questions, or would like more information, please email us at policy@rnzcgp.org.nz

Nāku noa, nā

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Executive summary

Women are not well served by the current siloed approach to maternity care in New Zealand, which sees them transferred from their usual general practice care, where they have history and continuity, to maternity care, then back again following birth, or the end of a pregnancy.

The College sees several issues with the Draft Primary Maternity Services Notice (Section 88). These are:

- Māori are significant stakeholders in this work given they are significantly over-represented among maternal suicides and the loss of pēpi to very preterm labour. We are surprised and disappointed that is seems Māori consultation was not made a priority for this review.
- The College would like to see a new approach to funding care for pregnant women, where financial barriers are removed regardless of whether they present to their GP or to maternity care.
- We recommend that the Ministry of Health convene a working group to focus on improving communication and therefore integration between GPs and midwives.
- We recommend that funded third trimester and postnatal GP visits be introduced.
- We need the first antenatal appointment to be at least 30 minutes long and be funded as such.
- GPs will not be paid if a woman presents for the first time in the second or third trimesters. However, we know this situation is a common occurrence in high needs communities.
- Communication between GPs and LMCs continues to be hindered by the lack of a secure digital communication method.
- There needs to be clarity about the qualifications that a GP requires to provide lead maternity care.
- Other issues we see include maternity ultrasounds, funding of early medical abortion, and consultations related to threated miscarriage.

Submission

The College supports the principle of a holistic approach to health care for women during pregnancy, including the exploration of alternative funding mechanisms for this care. We welcome the opportunity to discuss this further with the Ministry of Health (the Ministry).

With respect to our submission, we have chosen not to follow the feedback template as the issues that we wish to highlight are not covered by the template. We have indicated the clauses of the notice that each comment refers to for reference.

Our submission is structured to reflect the following topics:

1. Environmental context
2. Design principles
3. Equity and Māori
4. Integration
5. Primary maternity single services
6. Lack of clarity in the Notice
7. Other issues

1.Environmental Context

The College welcomes this long overdue review of the Section 88 Notice and sees the benefit of the review in the content of other significant activities relevant to maternity care, The Health and Disability System Review and the Maternity Action Plan.

The Health and Disability System Review

The College hopes that the Health and Disability System Review recommended changes to the maternity sector, with maternity services organised by locality rather than nationally, and with better connections to Tier One services will facilitate much needed integration between general practice and maternity services. Women are not well served by the current siloed approach, which sees them transferred to maternity care for the duration of each pregnancy then back again to general practice care between and following pregnancies. At these transition points there is an erosion of continuity of care, exacerbated by the difficulty in information transfer between providers.

The Maternity Action Plan

The details of the Maternity Action Plan are awaiting Cabinet approval, and the College is aware that the Ministry of Health has already recruited staff to work on the Action Plan. It is difficult to comment fully on the review of the Section 88 Notice without an understanding of the Action Plan. The College would appreciate the opportunity for further discussions with the Ministry maternity team once the Maternity Action Plan has been released.

2. Design Principles

The four design principles for the Notice review are:

- Whānau -centred
- Fair
- Flexible
- Sustainable[1]

The College contends that significant changes need to be made to ensure draft Notice is in keeping with the four principles stated in the discussion document. We have provided some examples where the College believes the draft Notice conflicts with the four stated principles. We recommend the Ministry look to address these identified discrepancies.

3. Equity and Māori

There is considerable evidence of inequitable maternity outcomes for Māori. The 2018 report of the National Maternity Monitoring Group (NMMG) includes the following observation:

"There is a significantly higher, almost double, maternal mortality ratio among Māori hapū māmās than New Zealand European hapū māmās. Māori māmā are over-represented among maternal suicides and the loss of pēpi to very preterm labour."

Stevenson in the *New Zealand Medical Journal* (June 2020) notes that Māori babies pēpi are more likely to be born pre-term and considers that "The maternal-infant healthcare system is failing Māori, evident in the maternal and infant health inequities between Māori and non-Māori".

The College considers addressing such inequities urgent and engagement with Māori and others overrepresented in adverse maternity outcomes must be a priority for the Notice review and for other work in the maternity sector.

With this in mind, the College was disappointed to read on page eight of the discussion document, that the draft revised Notice has progressed to the stage of release for consultation **without engagement with Māori maternity sector stakeholders** (our emphasis).

[1] https://www.health.govt.nz/system/files/documents/publications/primary-maternity-services-notice-review-2021-discussion-document-4sept2020.pdf Page 5 Accessed 5/11/20

The College has taken note of, and agrees with, the work done by the Ministry of Health in its Te Tiriti o Waitangi Framework, and how Te Tiriti is given expression in the organisation of the health and disability system. This is forward thinking given the possible implications of the Health and Disability System Review, and the first report of the Wai 2575 Waitangi Tribunal claim.

The principle of partnership requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

The College notes that this is not currently the case with the Section 88 Notice and recommends that the Ministry urgently takes steps to comply with its own principles.

Once this is done the College would like to have a further conversation or another opportunity to review the Notice, incorporating the partnership work with Māori, before the Notice is finalised.

PRINCIPLE	DESCRIPTION	CONFLICTS UNDER THE PROPOSED CHANGES
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.	GPs know that the first antenatal appointment needs at least 30 minutes (a double appointment) to complete the appropriate assessments. This should be funded as a such. As proposed, a woman would need to visit their GP on two occasions, on different days, which is impractical. Women seeing a GP in the second or third trimester or postnatally will need to pay for this consultation even if the Lead Maternity Carer (LMC) has advised the woman to see her GP, in keeping with the requirements of the referral guidelines.
Fair	Work done equals work paid.	GPs will not be paid if a woman presents for the first time in the second or third trimesters. However, we know this situation is a common occurrence in high needs communities. GPs will not be paid when they see a woman in the second or third trimesters or postnatally even if the LMC has advised the woman to see her GP, in keeping with the requirements of the referral guidelines.
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.	All consultations must be in person to be funded. There is no flexibility to fund virtual consultations. This does not recognise the relative immunocompromise of pregnancy and the associated vulnerabilities in situations such like the COVID-19 pandemic.
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.	GPs will not be paid when they see a woman in the second or third trimesters or postnatally even if the LMC has advised the woman to see her GP, in keeping with the requirements of the referral guidelines. Non-LMC fees are inadequate for the work currently done by GPs. Non-LMC fees have had minimal increase since 2007.

Additional design principles

To ensure that the revised Notice is fit-for-purpose the College recommends the following design principles also be included in the development of the revised Notice:

- Integrated approach to Maternity Care
- Safety
- Best Practice.

4. Integration

The College considers that seamless integration between general practice and midwifery is a key enabler of quality woman-centred maternity care. Midwifery and general practice currently exist in separate silos resulting in inefficiencies, inconvenience for women, and clinical risk. These silos are exacerbated by the proposed Notice and the review appears to be missing the opportunity to achieve better integration across providers.

Communication between GPs and LMCs continues to be hindered by the lack of a secure digital communication method. Work on establishing a suitable platform has been underway since at least 2010 and has not yet been delivered. As the health sector, women and whānau wait for the delivery of this system, there continues to be inefficiencies, risks, and repetition of assessments. The College recommends that the Ministry prioritise the completion of this work.

The College proposes the following initiatives that will improve integration between maternity care and primary health care.

Communication Working Group

The College recommends the Ministry establish a working group to focus on improving communication in the maternity sector between GPs and midwives. We suggest that the working group addresses:

- communication to the LMC at the beginning of pregnancy
- communication from the LMC to the GP at six weeks postpartum, and
- communication between midwives and GPs as issues arise during the pregnancy.

Strengthened communication should also include providing information from midwife to GP about why women are advised to see their doctor. We have anecdotal reports of women being unaware of why the midwife has asked them to see their GP, so not being able to communicate the issue when they're there, which can increase clinical risk.

Third trimester GP visit

The College recommends the Ministry introduce a funded third trimester GP visit with communication back to the LMC. The College considers that this would result in improvements in:

- Immunisation rates: This visit would enable immunisation to be discussed at a time when the mother is likely less stressed. Women, especially those with concerns, can be provided good quality advice and suggestions of where to obtain evidence-based information to inform their decision on immunisation. It would also act as a 'pre-call' for the six-week immunisations to ensure that the practice has the baby on its recall system.
- Pertussis (and influenza) immunisation rates for the mother
- Planning for postnatal contraception.

The third trimester visit would also provide the opportunity for a baseline mental health assessment and the establishment of a therapeutic relationship to enable disclosure and management of mental health issues. As we know, suicide is the leading cause of maternal deaths in New Zealand.

Postnatal GP visit

We also encourage the Ministry to introduce a funded postnatal visit for the mother. This would enable:

- Initiation of contraception if not already prescribed
- Screening for developing mental health issues

Part 5: Primary maternity single services

Part 5 of the discussion document outlines the changes most relevant to general practitioners. The proposal is to replace the current single non-LMC first trimester claim (covering the whole first trimester) with multiple single service claims for care during the first trimester. Funding for urgent non-LMC care is to be removed, leaving no means to fund maternity care provided by GPs in the second and third trimester, or postnatally.

The depiction of non-LMC first trimester care in section 5

Part 5 of the discussion document contains three statements that the College would like to comment on.

"It [non-LMC first trimester care] was introduced when LMCs did not generally provide first trimester care" (p.21)
We question this statement. Non-LMC first trimester care was introduced in 2007 during the most recent revision of the Primary Maternity Service Notice. The fee for non-LMC first trimester care could only be claimed once at the end of the first trimester and was intended to cover all GP consultations during that trimester. A higher fee was claimable if the woman experienced a miscarriage, threatened miscarriage, or was uncertain whether she wished to continue with the pregnancy.

The LMC could claim for seeing the women during the first trimester even if the woman also received non-LMC care from her GP. If the woman registered with the LMC before the end of the 17th week of pregnancy the LMC could claim the full first and second trimester module fee. 2 If the woman registered with a LMC in the first trimester but changed to another LMC before the start of the 18th week then the LMC could only claim the first partial fee.

However, there is a shortage of LMCs. Many of our members commented on the difficulty that their patients are experiencing in finding a midwife. To manage their workload, some overworked LMCs delay the first appointment with a new client until the very end of the first trimester. Meanwhile the woman sees her GP. The LMC is still able to claim the fee for the first trimester so long as she sees the woman before the end of the 17th week of pregnancy.

"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." (p.21)
The College agrees that the amount able to be claimed does not reflect the amount of work that is required to undertake a comprehensive first antenatal appointment and provide ongoing care during the first trimester. We are extremely disappointed that the Ministry has elected to respond to this discrepancy by curtailing the service specification, rather than increasing the fee.

We are aware that setting fees is not part of this consultation. However, the fee is problematic because it is unfair and because it sends a message regarding the amount of time and effort that the Ministry expects general practitioners to devote to a first antenatal appointment and to first trimester care.

"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".
The College would like to see an improvement in communication between GPs and LMCs as this would significantly improve integration and be of huge benefit to women. As mentioned earlier in large part this issue is due to the lack of a secure digital means of communication.

First trimester care provided in general practice

A high proportion of pregnant women do not see a LMC at all in the first trimester. The most recent data shows that among women in the lowest deprivation quintile only 53 percent had registered with a LMC by the end of the first trimester. Among Pacific women the rate was even lower, only 38 percent. The corresponding percentage for Māori was 55 percent. [3]

[2] https://www.health.govt.nz/system/files/documents/publications/s88-primary-maternity-services-notice-gazetted-2007.pdf
[3] https://minhealthnz.shinyapps.io/Maternity_report_webtool/_w_f5393186/#tab-1763-5 Accessed 12/10/20

These statistics are a cause for considerable concern, and we are dismayed that the Ministry is proposing to curtail the scope of the first trimester care that many of these women are receiving from their general practitioner. We acknowledge that there is currently variation in the level of first trimester care provided by general practitioners. The sector itself is responding to this variation by embracing tools such as the Best Start Pregnancy Tool, an output from the Generation 2040 project.

The College believes that GPs should be supported to use their skills to provide women with a comprehensive first antenatal assessment, and antenatal care up until the time that the woman is able to be seen by her LMC of choice. Lowering the expectations of and support for early antenatal care provided in general practice will deprive women of care necessary to maximise their health and wellbeing and ensure the best start for their baby.

The first antenatal assessment
An indication of the magnitude of what needs to be covered in this assessment is indicated by the Hapū Māmā Connecting (HMC) first trimester tool[4] produced for use by GPs during the COVID lockdown.

The HMC tool was developed to help ensure the time sensitive actions that need to occur early in pregnancy to address the modifiable risk factors for poor maternity outcomes happened during the lockdown. They were particularly useful for GPs in areas with a strong LMC workforce, who were less accustomed to providing early antenatal care.

Examples of such actions include:

- folate supplementation to decrease the risk of neural tube defects,
- iodine supplementation to decrease the risk of congenital hypothyroidism
- screening for Down syndrome and other conditions
- screening for STDs
- changing medications contraindicated in pregnancy (e.g. for epilepsy)
- identifying or optimising care for diabetes or hypertension
- identifying women who use tobacco (or other drugs) and assessing cessation support
- advising re alcohol use
- advising re diet – including foods to avoid due to listeria risk.

Removal of the ability to claim for urgent pregnancy care.

The Ministry is proposing to no longer fund urgent non-LMC care. The discussion document provides the rationale for this as "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 College considers that the removal of funding for urgent non-LMC care will have serious unintended consequences for women and babies.

This funding is currently used by GPs to avoid having to charge pregnant woman a fee when they present requiring maternity care. It is unsurprising that there is variation between practices in the extent to which they claim this fee. The distinction between what is and is not maternity care is problematic and likely to be interpreted differently by practices. The fee is currently set at inadequate level for an appointment not subsided by capitation as is the case for maternity care[5].

The College is concerned that the removal of this funding will mean that when women are seen in general practice for pregnancy care after the first trimester the GP will either have to charge them for this care, or provide this service gratis.

There is a shortage of LMCs in many areas of New Zealand. The College considers that the LMC workforce is those areas may not have the capacity to absorb the additional 30,000 consultations that could result from the proposed change. In addition, particularly in rural areas, it is unrealistic to expect women to travel long distances to access

[4] https://www.wgtn.ac.nz/health/centres/centre-for-womens-health-research/covid-19-project-hapu-mama-connecting-hmc accessed 10/11/2020
[5] https://tas.health.nz/assets/Uploads/PHO-Services-Agreement-Version-7.2-1-July-2020.pdf page 49. Accessed 12/11/2020

DHB services when care could be provided locally.

6. Lack of clarity in the Notice

The College considers that the draft Notice provides insufficient clarity on three issues:

1. What is considered a primary maternity service?
2. Which services provided after the first trimester must be free of charge?
3. The qualifications a GP requires to provide lead maternity care.

What is considered a primary maternity service (B1 (1) (a))

The revised definition has become circular and consequently does not provide a usable definition. With the removal of mention of non-LMC services it now reads:

*"In this notice **primary maternity services:***

(a) means the following services:

(i) Lead maternity care

(ii) Primary maternity services provided by a practitioner who is not the registered LMC; and

(b) does not include any of the following:

While a list of specific services that are not a primary maternity service follows (e.g. termination of pregnancy) there are many issues that pregnant women consult their GPs about that are not specifically excluded. In addition, clause B1 (1) (b) (xiii) references the service specification for maternity non-LMC services. This service specification is not included in the 2020 draft.

Clause B1 (1) (b) (xiv) reads "other services not specified in this notice". Does this mean that to be a primary maternity service, the service must be specified in the draft? It would be useful to have a list of services that are considered primary maternity services. For example, if an LMC advises a woman to see her GP regarding her depression or anxiety, is the GP visit considered a primary maternity service? The LMC is required by the Referral Guidelines[6] to give this advice. Prior to 2007 the referral guidelines were an appendix to the Notice.

The lack of clarity around the definition of primary maternity services has ramifications that extend to the PHO Services Agreement. Primary maternity services are defined in the PHO Services Agreement by reference to the definition in the Notice.[7]

Which services provided after the first trimester must be free of charge?

Relevant information can be found in the following clauses.

DA3 Charging for primary maternity care:

"Lead maternity care provided by a midwife LMC or general practitioner with a Diploma in Obstetrics LMC is to be provided free of charge to persons who are eligible to receive it under this notice."

DB2 Charging for primary maternity single services

"The primary maternity single services that are described under this contract are to be provided free of charge to persons who are eligible to receive these services."

Neither of these clauses address the situation of primary maternity care occurring after the first trimester, for example a first appointment with a pregnant woman.

The qualifications a GP requires to provide lead maternity care.

The 2007 Notice specified the Diploma of Obstetrics "or equivalent as determined by the (Royal) New Zealand College of General Practitioners" [8] as the Qualification that GPs required to provide lead maternity care. Although

[6] https://www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines Accessed 12/11/2020

[7] https://tas.health.nz/assets/Uploads/PHO-Services-Agreement-Version-7.2-1-July-2020.pdf Part H p133 Accessed 12/11/2020

[8] https://www.health.govt.nz/system/files/documents/publications/s88-primary-maternity-services-notice-gazetted-2007.pdf Section B5 Accessed 12/11/2020

the Diploma in Obstetrics is mentioned in clauses DA3, DA7, DA36, and DA13 of the draft Notice in relation to issues such as charging, and delegation it is no longer mentioned in the definitions.

The Diploma in Obstetrics has been replaced by the Diploma in Obstetrics and Medical Gynaecology. The College recommends that the Diploma in Obstetrics and Medical Gynaecology be included alongside the older Diploma in Obstetrics, which although no longer available is still held by some GPs.

Section DA6 (1) (c) (i)

The wording of section DA6 (1) (c) (i) states that the LMC will be responsible for providing or ensuring care is provided to the woman throughout her pregnancy and postpartum period, including all care required during pregnancy. The care that is being referred to does not appear to be restricted to maternity care. We suggest that the wording of section DA6 (1) (c) be changed to make it clearer that the LMC is responsible only for maternity care.

7. Other issues

Maternity ultrasound scans

The College supports the proposal not to include the reason codes in the Notice and instead refer to the list of indication codes available on the Ministry of Health website. (Section DD2 (3)). This will enable work on reducing unnecessary ultrasound scans, addressing the financial barriers that women experience in accessing scans that are clinically indicated, and implementing the recommendations of the Maternity Ultrasound Advisory Group (MUAG) on which the College was represented.

Requirement for consultations to be in-person

The College considers that the requirement that consultations must be in person (DB8 (2)) if a claim is to be made is ill advised. In-person is defined as being in the same room together in section B 5 virtual consultations are explicitly excluded. COVID 19 has shown that there needs to be flexibility around service provision, and it may be appropriate for consultations to be virtual in some circumstances, particularly as pregnancy can be associated with a degree of immunocompromise.

Funding of early medical abortion (EMA)

We note that abortion is specifically excluded from the Notice. (B1 (1) (b) (viii), however referral for a termination of pregnancy is included in the service specification (DB9 (1) (b). There needs to be a decision soon around how consultations for EMA, which may not require a referral, will be funded in general practice.

Funding for consultations related to threatened miscarriage

We would like to draw your attention to what could be viewed as a mismatch between service specifications (DB 9 (1) and the payment rules DB10 (1) relating to threatened miscarriage. The wording can easily be interpreted to mean that the additional fee, considering the additional time and resources required, can be claimed only if the woman miscarries and not if the pregnancy continues. We recommend that the wording be revised to make it clear that claims can made for consultations where the pregnancy continues after a threatened miscarriage. This would be in keeping with the payment rule DB11 (2) in the current (2007) Notice.