Office of Hon Dr David Clark

MP for Dunedin North
Minister of Health

Associate Minister of Finance

22 AUG 2018

Hon Michael Woodhouse
Michael.Woodhouse@parliament.govt.nz
NationalOIA@parliament.govt.nz

DCOIA221

Response to your request for official information

Dear Hon Woodhouse

I refer to your official information request received on 7 August 2018, in which you request the following information under the Official Information Act 1982 (the Act):

> *"Further to your reply to Written Parliamentary Question 14851 (2018), under section 12 of the Official Information Act 1982, I request the following documents:*
>
> · *HR 20171717: Update on the settlement with the New Zealand College of Midwives*
> · *HR 20171829: Briefing for the meeting with New Zealand College of Midwives on 19 December 2017*
> · *HR 20180412: Status of midwifery co-design process and package of measures to support LMC community midwives*
> · *HR 20180714: Aide Memoire: Meeting between New Zealand College of Midwives and the Ministry of Health on 6 April 2018"*

The four documents requested are attached as Appendix One, subject to the redactions noted in the table below.

Title	**Information Released/Withheld under the Act**
HR 20171829: Briefing for the meeting with New Zealand College of Midwives on 19 December 2017	Partially released. Redactions made pursuant to: - section 9(2)(a)
HR 20171717: Update on the settlement with the New Zealand College of Midwives	Partially released Redactions made pursuant to: - section 9(2)(a) - section 9(2)(h) - section 18(d)
HR 20180412: Status of midwifery co-design process and package of measures to support LMC community midwives	Partially released Redactions made pursuant to:

Title	Information Released/Withheld under the Act
	- section 9(2)(a) - section 9(2)(h) - section 9(2)(j)
HR 20180714: Aide Memoire: Meeting between New Zealand College of Midwives and the Ministry of Health on 6 April	Partially released Redactions made pursuant to: - section 9(2)(a)

You have the right to seek an investigation and review by the Ombudsman of these decisions.

Information about how to make a complaint is available at www.ombudsman.parliament.nz or free phone: 0800 802 602

Yours sincerely

pp

Bill Frewen
Ministerial Advisor

Appendix One

Health Report number: 20171829

Security classification: In-Confidence

Quill record number:
File number: AD62-14-17

Briefing for the meeting with New Zealand College of Midwives 19 December 2017

To: Hon Dr David Clark, Minister of Health

Copy to: Hon Julie Anne Genter, Associate Minister of Health

Purpose

You and Julie Anne Genter, Associate Minister of Health and Minister for Women are meeting with representatives of the New Zealand College of Midwives (the College) in your office on Tuesday 19 December 2017 from 4.15pm – 4.45pm.

Attending the meeting on behalf of the College will be

- Karen Guilliland, Chief Executive of the College
- Deb Pittam, President of the College and Midwifery Leader, Northland DHB
- Norma Campbell, Midwifery Leader, Canterbury District Health Board
- Nicole Pihama, Lead Maternity Carer (LMC) Midwife, Northland

Key points

- The College is the professional organisation for midwifery.
- Midwives are the major workforce providing maternity care for women, their babies and whanau in New Zealand.
- The Ministry of Health (the Ministry) and the College entered into interim and subsequent final settlement agreements to a claim filed in the High Court against the Ministry of Health in August 2015 for discrimination against midwife lead maternity carers (LMCs) on the grounds of gender in breach of section 19 of the New Zealand Bill of Rights Act 1990. The College may raise the settlement agreement with you.
- As a result of the settlement agreement, the College and midwife representatives have participated in a co-design process to develop a new funding and contracting model for community midwives to replace the Maternity Services notice pursuant to Section 88 of the Public Health and Disability Act 2000 (the section 88 notice).
- They wish to raise the following topics with you:
  - the outcome of the co-design and the Government's planned next steps with the proposed new funding and contracting model for community-based midwives (Lead Maternity Carers)
  - midwifery workforce issues across community and hospital maternity services
  - sustainability of rural midwifery
  - the Midwifery Council
  - midwifery leadership
  - Primary Care

Contacts:	Stewart Jessamine, Director, Protection Regulation & Assurance	s 9(2)(a)
	Bronwen Pelvin, Principal Advisor, Maternity, Protection Regulation & Assurance	s 9(2)(a)

Health Report number: 20171829

Briefing for the meeting with New Zealand College of Midwives 19 December 2017

- Briefing notes on these topics are in the body of this briefing.
- Jill Lane, Director, Service Commissioning will attend the meeting from the Ministry.

Recommendations

The Ministry recommends that you:

This report is for your information only and does not request any decisions.

Dr Stewart Jessamine
Director
Protection, Regulation and Assurance

Minister's signature:

Date:

Health Report number: 20171829

Briefing for the meeting with New Zealand College of Midwives 19 December 2017

Background

1. The New Zealand College Midwives (the College) represents almost 90 percent of the practising midwifery workforce. Its members are both self-employed and employed midwives with a national membership of 3100 members comprising of midwives, maternity service users and consumer organisations.
2. The College has a regional structure of ten committees and five sub committees in smaller provincial centres. There are 10 regions, the chairs of which come together as the National Committee, the governance board for the professional organisation. The College's governance structure allows for extensive networking at regional and national levels, ensuring that the College is responsive to midwifery and maternity service issues.
3. The College works closely with midwives, district health boards (DHBs), regulatory authorities, other disciplines and professional colleges, the Ministry of Health (the Ministry) and other government agencies to support the ongoing development of maternity services for women, their babies and whanau. The College has representatives on a number of national groups including the National Maternity Monitoring Group, the Perinatal and Maternal Mortality Review Committee, Health Workforce New Zealand's Midwifery Strategic Advisory Group, the Maternal Morbidity Working Group, the Maternity Clinical Indicators Expert Working Group as well as other advisory groups.
4. The College has been working for a number of years to alert the Ministry to the ongoing undervaluation of midwifery as a workforce and the inadequate compensation for the self-employed midwives who provide maternity care to women throughout pregnancy, labour and birth and until the baby is six weeks old. They consider the increases to the fees claimed under the section 88 notice have not kept pace with increases to DHBs and other providers in the health system.

Co-designing a community midwifery funding and contracting model

5. A project to co-design a new community primary midwifery funding and contracting model began in March 2017, as a result of the interim and subsequent final settlement agreements to a claim filed in the High Court against the Ministry of Health in August 2015 for discrimination against midwife lead maternity carers (LMCs) on the grounds of gender in breach of section 19 of the New Zealand Bill of Rights Act 1990.
6. The scope of the project was the development of a new funding and payment model for midwife LMCs currently paid through the Maternity Services Notice pursuant to Section 88 of the Public Health and Disability Act.
7. A Health Report (HR20171717) on the final recommendations resulting from the co-design and advice from the internal Ministry Project Steering Group on next steps is accompanying this briefing.

Midwifery workforce

8. There are four pre-registration midwifery programmes in New Zealand offered by Otago Polytechnic in Dunedin, Ara Institute in Christchurch, Waikato Institution of Technology (Wintec) in Hamilton and Auckland University of Technology (AUT) in Auckland. Several schools have satellite programmes such as Otago with a programme in Wellington and AUT with student cohorts in various sites in the upper North Island.
9. The schools take approximately 260-270 midwifery students each year. Their data shows an overall dropout rate of 33% over four years, with 15-20% occurring in the first year.
10. Health Workforce New Zealand (HWNZ) has a number of strategies in place to support and retain the midwifery workforce:
    - Midwifery First Year of Practice (MFYP) Programme
    - Midwifery Rural Retention and Recruitment Service

- Postgraduate Education Fund
- Voluntary Bonding Scheme.

11. The College holds the contracts for providing the MFYP programme, the Midwifery Rural Recruitment and Retention Service and the Postgraduate Education Fund.
12. Despite this activity there are significant gaps in the midwifery workforce in many parts of the country, both in DHB core midwives and in LMC community midwives. Auckland Metro DHBs and Mid Central DHB regions are particularly affected, with supply problems both in DHB and LMC services. In addition to this, the Auckland Metro DHBs are facing a projected 21 per cent increase of births by 2022.
13. The Maori and Pasifika midwifery workforces are small and retention of the few Maori and Pasifika midwives is an ongoing challenge. Maori and Pasifika midwives often provide care for women and families with highly complex health and social needs.
14. HWNZ workforce data demonstrates the scale of the issue with midwifery attrition rates. The average national annual exit rate of DHB core midwives is 18 per cent. However, in seven DHBs, the average proportion of midwives under 50 leaving the workforce is 30 to 36 per cent. In two small rural DHBs, the exit rate is 44 per cent. Five per cent of DHB midwives leave to work as LMC midwives and 10 per cent of LMC midwives move to work in DHBs the following year. Of the total midwifery workforce, approximately 7 per cent of midwives work in both care settings.
15. Predictive modelling based on information provided by the Midwifery Council on each individual midwife's working patterns over time are showing an overall decline in the total workforce Full Time Equivalent (FTE) against the increase in the predicted birth rate.
16. The College is concerned that the remuneration for both employed and self-employed midwives is negatively impacting on retention of the workforce and the provision of maternity services to women both in the community and in maternity facilities.

Rural midwifery

17. Midwives practising as LMCs in rural locations face particular challenges. Because of the distances and travel involved, a rural midwife may have access to only a few women locally and may struggle to achieve a caseload that provides adequate remuneration. Rural midwives are frequently expected to manage aspects of complex care, make instant decisions and summon emergency assistance e.g. ambulance, helicopter. The midwife may be the only health professional available and may be called on to provide assistance for accident and emergencies in some remote rural areas.
18. The College thinks that rural and remote rural travel funding (rural: $256 and remote rural: $454) and the one-off Labour and Birth (rural support) fee ($568 for the supporting health practitioner) available in the section 88 Maternity Services Notice does not compensate for reduced caseloads or additional responsibilities.
19. There are a number of primary maternity facilities in rural locations but usually they are staff on an 'on call' basis and when women and babies are in residence. Over the last 5 years, a number of rural primary maternity facilities have been closed by DHBs due to lack of financial sustainability. This impacts women and midwives who must travel, sometimes upwards of 2 hours to access the nearest base hospital. Access to birth facilities for rural women is often dependent on access to road travel, availability of ambulances and emergency air ambulances.

Midwifery Leadership

20. The Midwifery Strategic Advisory Group of Health Workforce New Zealand has identified midwifery leadership as an item for its work programme. The majority of DHBs have a recognised midwifery leadership role but there are a variety of reporting lines across the country. The midwifery workforce is often grouped in with the nursing workforce despite differences in scopes of practice.
21. There is a DHB Midwifery Leaders group that meets regularly throughout the year. This group has only recently received organisational support from DHB Shared Services and not all DHB midwifery Leaders are supported by their DHBs to attend.

22. The College believes the group is concerned mainly with DHB operational issues and struggles to consistently demonstrate leadership both at individual DHB level and also nationally. The group is only beginning to engage with both the College and the Ministry Maternity Advisors. There is a need to support leadership development for midwives in leadership roles in DHBs especially to ensure they represent all of the profession, not just those midwives employed by the DHBs.

The Midwifery Council

23. The Midwifery Council's role is defined in the Health Practitioners Competence Assurance Act 2003 (HPCAA) which was passed in 2003. The Act established separate Regulatory Authorities to enact the legislation for each group of health practitioners.
24. The Midwifery Council meets its obligations to protect the public is by having a robust registration process; an annual practising certificate process and recertification requirements to maintain essential skills. Processes are in place for members of the public to complain or seek further advice if they are not satisfied with the care they have received from a midwife.
25. The College is interested in discussing the appointment process to the Midwifery Council. The College is no longer consulted regarding appointments and nominees from the College are not always appointed. They may also wish to raise the matter of electing some Midwifery Council members.

Primary Care

26. The Primary Health Care Strategy 2000 envisioned primary health care putting a greater emphasis on population health, the role of the community, health promotion and preventative care, the need to involve a range of professionals and the advantages of capitation funding to meet population health needs. The intent was to offer people access to a comprehensive range of health services.
27. The term 'primary care' is now used to describe mainly health services provided by general practitioners and nurses. The College thinks that other components of primary health care such as primary maternity care, Well Child Tamariki Ora services, pharmacy, oral health, podiatry and so on have remained in isolation without benefitting from infrastructure support and multi-disciplinary collaboration.
28. The Ministry holds a contract with the College (expiring 30 June 2018) to trial the development of infrastructure and local clinical leadership to enable community midwifery to be part of DHB/PHO Alliance arrangements and integration activities. This contract is also working to deliver coordinated IT infrastructure for community midwifery including electronic access for women to their midwifery record, discounted national purchase of Connected Health (access to electronic laboratory and ultrasound reports) and has enabled the College to become a member of the Primary HealthCare Alliance.

END.

MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report number: 20171717

Security classification: Sensitive-Budget

File number: AD-62-14-2017
Action required by: 18 December 2017

Update on settlement with the New Zealand College of Midwives

To: Hon Dr David Clark, Minister of Health

Purpose

- This memo provides you with the papers developed as a result of a co-design project with the New Zealand College of Midwives (NZCOM) as part of a settlement of a High Court claim, and advises you on potential next steps.
- You are meeting with Karen Guilliland, Chief Executive of NZCOM, on Tuesday 19 December 2017. We recommend you meet with officials before meeting with NZCOM.

Key points

- On 16 May 2017, the Ministry agreed to undertake a co-design project with the New Zealand College of Midwives (NZCOM) as part of a settlement of High Court proceedings undertaken by NZCOM. The proceedings claimed underfunding of Community Lead Maternity Carer midwives, with specific allegations of gender discrimination (see Appendix 1, which sets out the settlement clause by clause).
- This co-design process is now complete. The co-design team has made recommendations on a new community primary midwifery funding model and payment model, including recommendations on fair and reasonable remuneration (see Appendix 2).
- The overall recommendations of the co-design team are to establish a national community midwifery organisation that holds a national contract to support the workforce and to fund contracted midwives via a new 'blended' payment model that approximates the real costs of services, provides fair and reasonable remuneration to community midwives, and meets the variable needs of individual pregnant women.
- The co-design team assessed fair and reasonable remuneration for the work of a community midwife to be a total of $241,000 per FTE (including payments to recognise 24/7 on call expectations and business operating costs). If the proposed model was adopted, it would cost $353 million per year. This is an increase of $237 million per year above current funding levels.
- The Ministry's initial advice is not to proceed to implement the recommendations of the co-design team. We are concerned the proposed model would not uphold good practice. It would also have significant flow-on effects for workforce relativity that would impact on other providers of maternity services, and on wider health care services. The proposed model is unlikely to be affordable for Government in the short or long term.
- As the community primary midwifery co-design project arose from the legal action, DHB-funded services were not included in the scope. We consider a new model of care needs to consider wider maternity services, and a design that will best deliver health outcomes in a cost-effective manner. You may wish to consider alignment with your broader aspirations for the primary care sector.
- There remain critical issues to manage relating to the stability of the midwifery workforce more generally. You may wish to consider options in this regard as part of Budget 2018. A Budget bid of $4 million has been prepared in recognition of the co-design work, but will not be enough to

satisfy NZCOM that progress is being made. We will seek your direction on our approach to Budget.

- You and Minister Genter are meeting with Karen Guilliland, Chief Executive of NZCOM, on Tuesday 19 December 2017. You have invited officials, Jill Lane, Director Service Commissioning and Clare Perry, Group Manager, Service Commissioning to the meeting with NZCOM.

Recommendations

The Ministry recommends that you:

a)	**Seek** to meet with officials before meeting with the New Zealand College of Midwives on 19 December.	No time Yes/No
b)	**Note** that the Budget 18 Bid for Midwifery has been prepared by the Ministry that includes $4 million ongoing in recognition of the co-design work being completed.	Noted
c)	**Note** that the $4 million is well below the recommendations of the co-design project.	Noted
d)	**Agree** that the Ministry develop a scope for a broader piece of work that will consider the model of care for maternity services, including alignment with work on primary care, for you to consider next year.	Yes/No
e)	**Note** we will work with your office on a strategy for maintaining a constructive relationship with the New Zealand College of Midwives, and mitigating the risk of the College re-initiating proceedings against the Ministry.	Noted
f)	**Forward** a copy of this Health Report to Hon Julie Anne Genter, Associate Minister of Health, for her information.	Yes/No

Jill Lane
Director
Service Commissioning

Minister's signature:

Date: 18/12/17

Contacts:	Jill Lane, Director, Service Commissioning	s 9(2)(a)
	Hannah Cameron, Deputy Chief Policy Officer, Strategy and Policy	s 9(2)(a)

Background

Maternity Care in New Zealand

2. New Zealand has maternal and infant health outcomes comparable to or better than many other developed countries.[1]

3. However, our maternity services face a number of challenges. There is a need to:
   - address longstanding remuneration concerns
   - improve timely access to maternity services to some population groups
   - address current and forecast workforce shortages in some areas (especially in Auckland and in rural areas)
   - better support maternity services to provide the appropriate level of care to pregnant women with complex health and social needs.

4. The Ministry currently purchases community primary maternity services from Lead Maternity Carer midwives (community midwives), general practitioners and obstetricians under the Primary Maternity Services Notice pursuant to Section 88 of the Public Health and Disability Act 2000 (the Notice). Community midwife services provide the bulk of the Primary Maternity Services and account for around 80 percent of the total spend under the Notice (approximately $116 million out of $145 million in 2016/17). There are approximately 1238 LMC midwives (headcount), or 1149 FTE (file number 20171708 refers).

5. District health boards (DHBs) also employ approximately 1386 midwives (headcount), or 969 FTEs. These DHB midwives work in hospital settings and provide services to women and families who choose not to or cannot get a community midwife. You were provided with background information on the midwifery workforce on 5 December 2017 (file number 20171708 refers).

Dispute with the New Zealand College of Midwives and resulting settlement agreement

6. In August 2015, in response to perceived failure to meaningfully address cost pressures and provide a responsive funding mechanism for community midwives, NZCOM filed a claim in the High Court against the Ministry of Health (the Ministry) for discrimination on the grounds of gender, in breach of section 19 of the New Zealand Bill of Rights Act 1990. It is worth noting that this case differs from pay equity cases because midwives are self-employed.

7. The case was settled following mediation which took place from August 2016 to May 2017. An immediate joint co-design process to review the community primary midwifery funding and payment model, including consideration of job size, was a condition of the mediated settlement agreement between the Ministry and NZCOM. It was also agreed that the Ministry would prepare a bid for the 2018 Budget that reflects the findings of the co-design process. The full text of the final settlement agreement, set out clause by clause, along with progress made in meeting each clause of the settlement, is set out in Appendix 1.

8. As this process arose from the legal action, DHB-funded services were not included in the scope of community primary midwifery co-design project. Changes to the community midwifery model of care were also excluded from the scope.

Recommendations of the co-design team

9. The co-design team identified significant issues regarding the current funding model and issues of concern to midwives, including high caseloads; a payment structure that incentivises the same level of care to all women, regardless of their needs; misdistribution of midwives around the country, with shortages in several areas; and a lack of 'infrastructure' to help midwives work as a coordinated workforce, or connect them with the wider health sector.

10. The co-design team considered, but dismissed, the following options:

[1] http://www.health.govt.nz/publication/comparative-study-maternity-systems

- fee-for-service payments to midwives, where midwives are paid for each 'module' of care they provide for a woman at different stages of her pregnancy (an updated version of the status quo, but with higher funding levels)
- employing midwives and paying them a salary (midwives do not support this option, because they prefer self-employment)
- the Ministry contracting directly with Lead Maternity Carer (LMC) midwives (similar to the status quo, but somewhat more flexible)
- the Ministry devolving funding to DHBs, which would then purchase community primary midwifery services (similar to other aspects of the health system, but strongly opposed by midwives).

11. The overall recommendations of the co-design team are 'to establish a national community midwifery organisation that holds a national contract to support the workforce and to fund contracted midwives via a new 'blended' payment model that approximates the real costs of services, provides fair and reasonable remuneration to community midwives, and meets the highly variable needs of individual pregnant women'.
12. The co-design team assessed fair and reasonable remuneration for the work of a community midwife to be $170,000 per FTE, with an additional $30,000 to recognise the 24/7 on call expectations of community midwifery, and an additional $41,000 to cover operating costs of self-employed community midwifery practice. As part of the methodology to assess fair and reasonable remuneration, the following health professionals were used as comparators: Resident Medical Officers, DHB employed midwives, general practitioners and pharmacists.
13. The blended payment model would keep some features of the status quo with increased remuneration, and adds some additional types of payment. Key aspects of this proposed new model are:
    - effectively setting the workload of 1 FTE of midwife care at about 40 births per year – which means approximately 42 hours of work per week, plus being on call and urgent call outs
    - additional funding to cover extra time spent by midwives with women, and extra travel costs, where midwives judge the woman needs more intensive support (expected to be about a quarter of women)
    - other initiatives that will address workforce sustainability issues – including a national locum service, recruitment and retention incentives, and extra payment for 'single service' episodes like miscarriage.
14. If the proposed model was adopted, it would cost $353 million per year for community midwifery LMCs only. This is an increase of $237 million per year.
15. The detailed reports developed by the co-design team are attached to this briefing as Appendix 2:
    a) Meeting Paper to the Steering Group with the co-design group's final recommendations, dated 5 December 2017
    b) Presentation: Paying and Funding the Community Centred Midwife in New Zealand, delivered to the Steering Group on 3 November 2017
    c) Community Midwifery Pricing Model: Report and Recommendations of the Community Midwifery Funding Co-design Project, November 2017
    d) Community Midwifery Payment Model: Report and Recommendations of the Community Midwifery Funding Co-design Project, November 2017
    e) Community Midwifery Funding Model: Report and Recommendations of the Community Midwifery Funding Co-design Project, November 2017
    f) Frequently asked questions

Ministry view on the proposed community primary midwifery funding model

16. In accordance with the terms of the settlement agreement, the co-design process has been completed and the Ministry formally received the report from the co-design team on 7 December 2017, including the findings of the job evaluation process. This has completed the work of the co-design process under settlement agreement, subject to the 2018 budget bid requirement.

17. Our initial advice is that the Government should not directly proceed to implement their recommendations.

18. The Ministry agrees with many aspects of the original problem definition of the co-design, and agrees that quick action is needed to support midwife recruitment and retention. We recognise the significant amount of work that has gone into the co-design process, including modelling, identification of pros and cons of the current system, and areas needing improvement. Maternity services offer important opportunities to engage with women and families, to address health inequalities and provide the best start in life. A payment model that provides incentives for additional time and support for women with high needs will be critical to realising these opportunities in the future.

19. The Ministry is not convinced that the co-design team's proposed model will deliver best outcomes for mothers and babies, improvements to midwives' working conditions, or value for money. In short, our main concerns include:

    - the status quo has resulted in midwives being considered to be on call 24/7, and the proposed model does not challenge this arrangement. The model assumes that one FTE is around 42 hours per week, in addition to on call expectations and urgent call outs. This would embed excessive working hours, an undesirable feature of the status quo that is not conducive to health and safety
    - the original limited scope of the co-design means there are unaddressed questions around how midwifery fits with other services used by women, to provide the best care possible. There is a further question about how midwifery should fit within Government's broad aims to improve primary care accessibility
    - there is a tension between midwives' desire to be self-employed, and an expectation that the Ministry will bear the costs and risks of midwives' practice (by providing start-up business costs, for example). This is inconsistent with the way the Ministry contracts with other health sector providers
    - the costs associated with the new model do not appear to be fiscally achievable either in the short or long term. There is a high risk that adopting this model would have significant flow-on impacts, and related costs, for other areas of health contracting and employment arrangements.

20. The high cost of the proposed model raises questions about whether its 'fundamentals' are right. If well designed, the model could contribute significantly to Government's goal of increasing child and maternal wellbeing. We therefore propose that further work is required to consider the broader model of care for maternity services, including whether or how this might be aligned with Government's aspirations for healthcare.

21. The Ministry considers there is significant risk that sending more funding through a system that is not optimally designed would create an unhelpful precedent and fail to achieve better outcomes, including for women and babies with the highest needs. In addition, by accepting in principle a model which cannot be fully funded, the Government may be at risk of a further claim in the future.

22. The settlement agreement stated that 'The Ministry will prepare a bid for the 2018 Budget. That bid will reflect the findings of the co-design and evaluation process'.

23. The Ministry has submitted a Budget bid that provides $4 million ongoing funding in recognition of the co-design work being completed.

24. The current amount of the bid will not be sufficient to satisfy NZCOM that progress is being made to fulfil the settlement agreement.

25. Health Workforce New Zealand (HWNZ) has commenced a midwifery project working with Ministry and sector stakeholders. This work seeks to:
    - take a whole of system approach
    - focus upon needs of women, babies and their whānau
    - examine barriers and enablers to the recruitment and retention of registered midwives in the DHB core and the LMC maternity services
    - identify further opportunities to ensure a sustainable midwifery workforce, across all care settings.

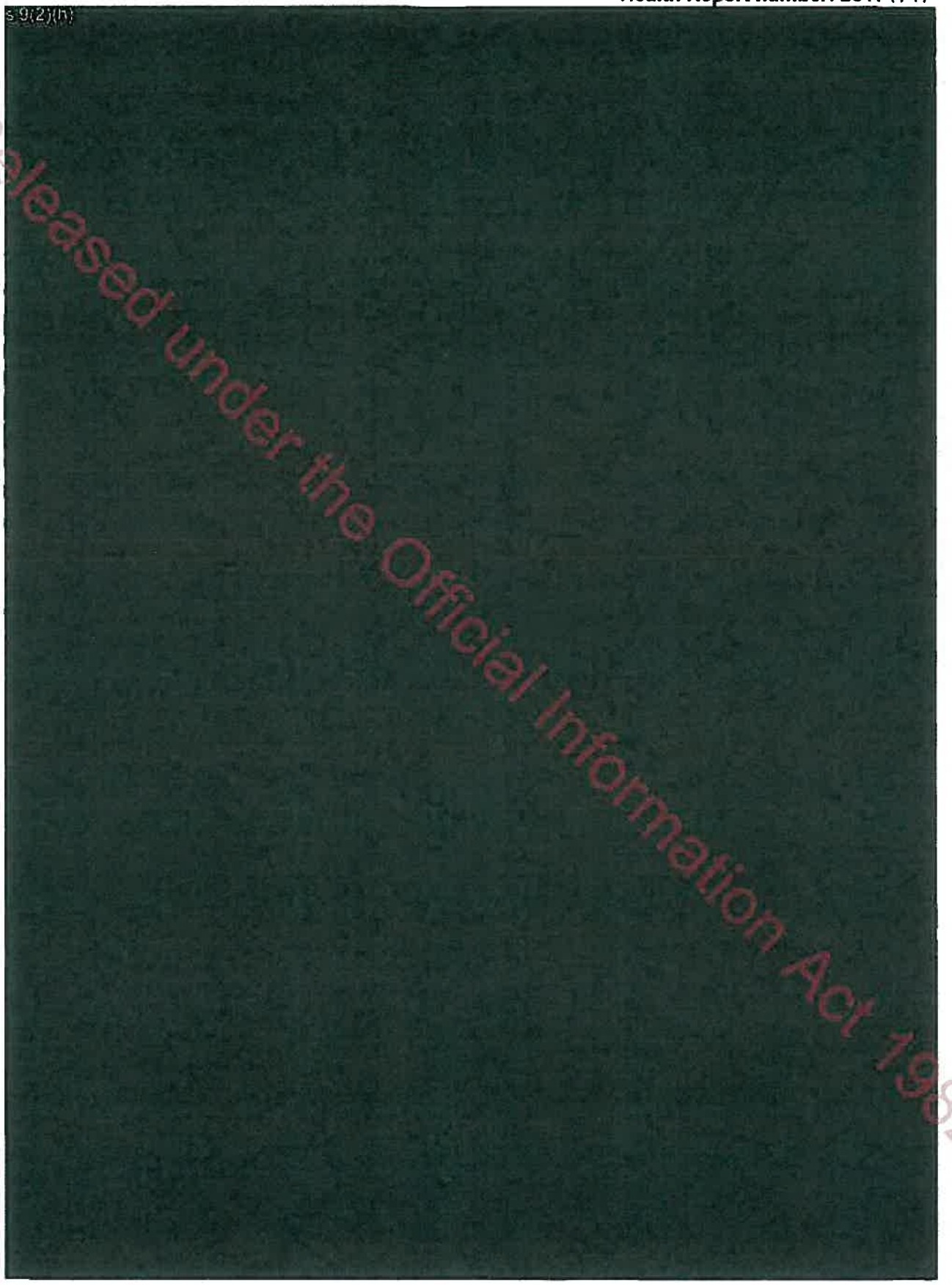
    This work will be completed in early 2018 and you will receive a comprehensive brief (HR 201717908 refers).

Next steps

26. For your meeting with NZCOM, we recommend that you discuss the broad problems NZCOM is seeking to address through the co-design process, and indicate that you would like to take further advice on the report.
27. We will seek your direction for revising the current Budget bid of $4 million, which recognises the completed co-design work. We will also work with your office on a strategy for maintaining a constructive relationship with NZCOM, and mitigating the risk that they will re-initiate proceedings against the Ministry.
28. We seek your agreement to develop a scope for a broader piece of work that will consider the model of care for maternity service, including alignment with work on primary care, for you to consider next year. As part of this broader work, we will seek additional expertise, including expertise on pay relativity, to further test the assumptions underlying the work to date.

Health Report number: 20171717

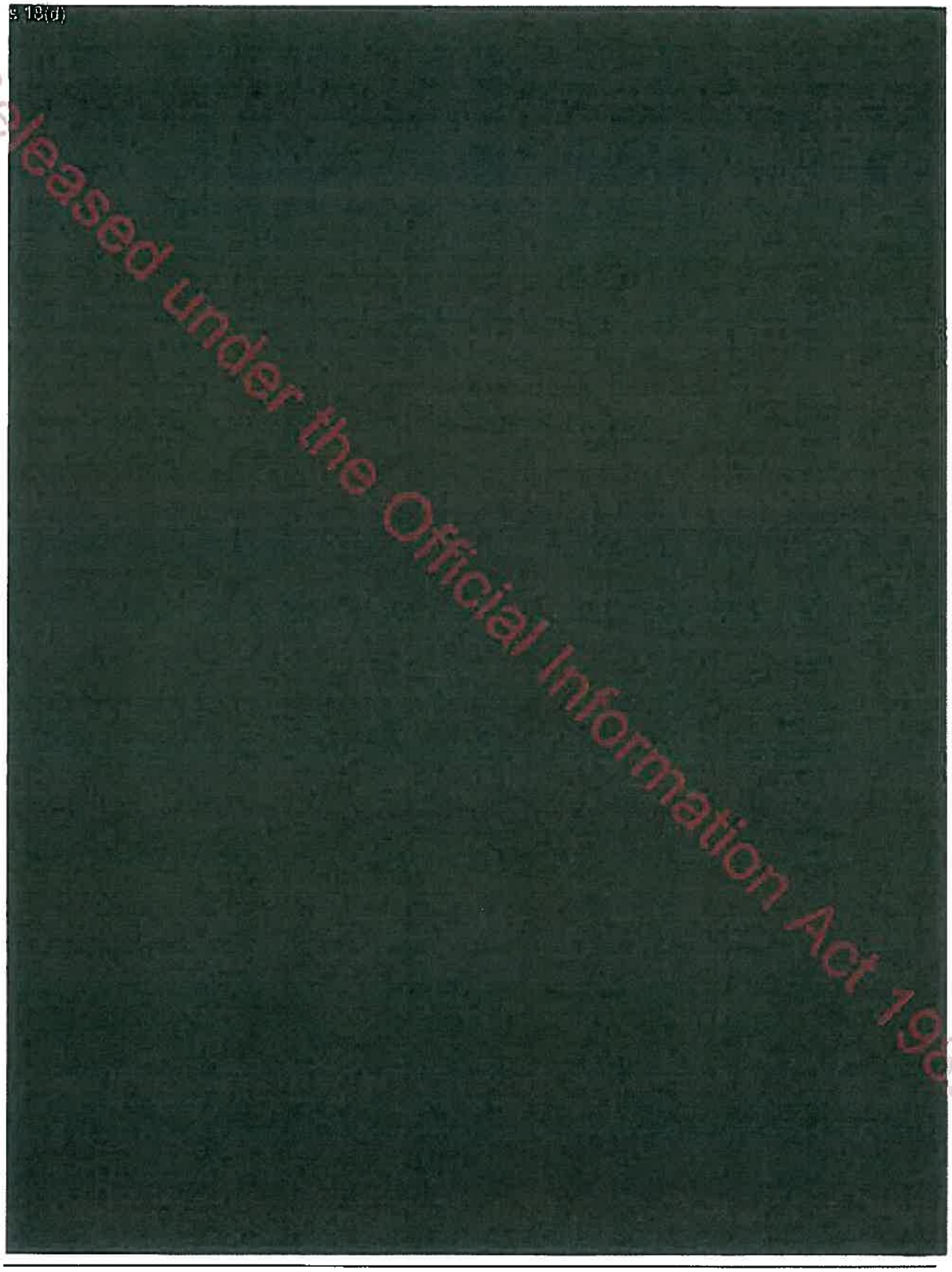
s 9(2)(h)



Appendix 1

Appendix 2

s 18(d)



MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report number: 20180412

Security classification: Sensitive-Budget

Quill record number:
File number: [generated by Records Help]
Action required by:

Status of midwifery co-design process and package of measures to support LMC Community Midwives

To: Hon David Clark, Minister of Health

Copy to: Hon Julie Ann Genter, Associate Minister of Health

Purpose

You have asked for information on the midwifery co-design process, and a package of measures that help address outstanding issues.

Key points

- The maternity co-design process has provided learnings and insights to take forward into the next phase of work; however the co-design recommendations do not align with a sustainable and fit for purpose maternity service. For these reasons the co-design recommendations cannot be supported.
- Health officials propose the following package of measures to better support LMC community midwives as part of Health's funding package for Budget 18:
    - $1.28m over three years to fund workforce retention initiatives
    - $12.5m uplift to Section 88 lead maternity carer modules to recognise the unusual time-lag in addressing price pressures for these services
    - $9m to address unfunded historical volume pressures
    - $6m for forecasted volume pressures (birth rate)
- You agreed in December 2017 to link future work on maternity services with the review of primary health care. Maternity services development must align well with any changes to hospital and primary health care services. A key focus must be that women experience improved access to safe, high quality services that meet the needs of mother and baby.
- If you are comfortable with the proposed approach, the Acting Director-General of Health will formally respond to the College on the outcome of the co-design process. The proposed key messages include:
    - acknowledge the benefits of the co-design
    - express a willingness to continue working with the College and use the good work within the co-design to inform future work
    - decline the co-design recommendations and the reasons why
    - share that Ministers are considering a package of measures to better support LMC community midwives while longer term work is completed
- Communication messages will be sent separately to your office tomorrow.

Contacts:	Jill Lane, Director Service Commissioning	s 9(2)(a)
	Clare Perry, Group Manager, Integrated Service Design	s 9(2)(a)

Health Report number: 20180412

Status of midwifery co-design process and package of measures to support LMC Community Midwives

Recommendations

The Ministry recommends that you:

a) Note the contents of this briefing Yes/No

Jill Lane
Director
Service Commissioning

Minister Clark's signature:

Date:

Health Report number: 20180412

Status of midwifery co-design process and package of measures to support LMC Community Midwives

Timeline of key events

- In August 2015, High Court proceedings against the Ministry submitted to the High Court by NZCOM. The proceedings claimed underfunding of Community Lead Maternity Carer midwives, with specific allegations of gender discrimination. (See Appendix 1, which sets out the settlement clause by clause.).
- The case was settled following mediation which took place from 15 August 2016 to 16 May 2017. The settlement agreement was confirmed by NZCOM ON 19 May 2017.
- As part of Budget 2017, a six percent increase in fees and 2.5 percent backfill was applied to the Notice as agreed with NZCOM in the settlement agreement, and confirmed by the Government in May 2017.
- A co-design process commenced in March 2017 to review the community primary midwifery funding and payment model, including consideration of job size, was a condition of the mediated settlement agreement between the Ministry and NZCOM (refer clause 2 in Appendix 1). It was also agreed that the Ministry would prepare a bid for the 2018 Budget that reflects the findings of the co-design process.
- Following concerns expressed by SSC about the application of the pay equity principles to a contracted workforce, the Ministry as part of the co-design process reached an informal understanding with the College that the co-design process would refer to "fair and reasonable remuneration" rather than pay equity.
- Weekly report item to Minister of Health (27 November – 3 December) providing an update on the co-design of a new community primary midwifery funding model indicating the work was near completion and the Ministry would provide advice to the Minister.
- The co-design project was completed in December 2017 with final recommendations received by the Ministry on the 7th of December. The co-design team made recommendations to the Ministry on a new community primary midwifery funding model and payment model, including recommendations on fair and reasonable remuneration.
- The Ministry provided initial advice to not proceed to implement the recommendations of the co-design team (HR20171717), see attached. Although the Ministry agreed with many aspects of the original problem definition of the co-design, and recognised the significant amount of work that had gone into the co-design process (including modelling, identification of pros and cons of the current system, and areas needing improvement), there were concerns that the proposed model would: not uphold good practice; have significant flow-on effects for workforce relativity that would impact on other providers of maternity services, and on wider health care services; and was unlikely to be affordable for Government in the short or long term.
- A cost pressure template for Maternity National Services was submitted to the Treasury on 8 December 2017, and on the same date the Minister of Health sent a letter to the Minister of Finance summarising the proposed cost pressure bids (including Maternity National Services) for consideration as part of Budget 2018.
- The Minister of Health and Minister Genter, with Ministry officials, met with Karen Guilliland, Chief Executive of NZCOM, on Tuesday 19 December 2017.
- The Ministry provided initial advice on the review of primary health care (HR20171863), including that the recommended option for the scope of the review includes activities and services under wider community based services including primary maternity services.

- The Ministry finalised its considerations of the maternity co-design process and concluded that the maternity co-design process has provided learnings and insights to take forward into the next phase of work; however the co-design recommendations do not align well with a sustainable and fit for purpose maternity service that reflects the approach and priorities of this Government. For these reasons, along with the reasons included in advice to Minister's in December 2017, the co-design recommendations cannot be supported.
- The Minister of Health and Associate Minister of Health met again with Ministry officials on Thursday 15 February 2018.
- The Health Workforce New Zealand Board received advice on 23 February. The briefing to Ministers provides an overview of New Zealand's maternity services, access issues and workforce trends.

s 9(2)(h)

[redacted]

Package of measures to support LMC Community Midwives

Revised Cost Pressures Bid in Health's funding package for Budget 18

	2017/18 $million	2018/19 $million	2019/20 $million	2020/21 $million	2021/22 $million	5 years $million
Volume (current gap)	9.000	9.000	9.000	9.000	9.000	45.000
Volume (2018/19)	0.000	6.000	6.000	6.000	6.000	24.000
Price (2018/19)	0.000	12.500	12.500	12.500	12.500	50.000
Other	0.000	1.280	1.280	1.280	0.000	3.840
Total	**9.000**	**28.780**	**28.780**	**28.780**	**27.500**	**122.840**

Details of Budget Bid

	Comment
Volume (current gap)	There is a $9m in volumes pressure based on the difference between the existing budget of $149.93m and the forecast expenditure. Over the past few years, the difference between the budget for this expenditure and the actual expenditure has been managed through one-off funding (contingency/risk pool funding and transfers of underspends from other appropriations through Order in Council). One driver of the additional cost is the growth in use of ultrasounds.
Volume (2018/19)	The $6 million pressure based on the forecast number of additional procedures, which is based on the expected number of births
s 9(2)(j)	[redacted]
Other	$1.28m over three years to fund workforce retention initiatives over three years can be funded through a mix of DHB reprioritisation and Ministry baseline: 1. Provision of a $7,000 training allowance for final year midwifery students in their final year of training. (60 students per annum - $1.295 million over 3 years - Prioritise Maori and Pacific) 2. Increase the number of Midwifery First Year of Practice support places by 60 per year(estimated cost $2.16 million over 3 years – Prioritise Maori and Pacific) 3. Mentoring and support of Australian midwifery graduates (26 places, $120,000 per annum).

Maternity services development as part of an integrated system

Ministers agreed in December 2017 to link future work on maternity services with the review of primary health care. Work on the future development of maternity services will ensure that primary community maternity services align well with any changes to primary health care services. A key focus must be that women experience improved access to safe, integrated, high quality services that meet the needs of mother and baby.

Considerations include:

- Understanding the changing nature of maternity services and what mothers and babies require for good outcomes
- Aligning work to the new Government priorities, for example the Child Wellbeing Strategy
- Ensuring over time that system level funding, contracting and accountabilities are delivering the right incentives and outcomes for mothers and babies
- Developing improved models of care that closely link with primary health care and Well Child Tamariki Ora services
- Working with Health Workforce New Zealand Board (HWNZ) to ensure the maternity workforce remains sustainable and fit for purpose.

The Government has other major reviews and strategy development underway that will have a direct impact on maternity services. The maternity service improvement project will need to:

- Work with the Advisory Group for the Review of Primary Health Care on how best to organise work to review maternity services, including models of care
- Work closely with the Maternity Quality Monitoring Group.

END.

MINISTRY OF HEALTH
MANATŪ HAUORA

17 APR 2018 **Health Report number:** 20180714

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AIDE MEMOIRE: MEETING BETWEEN NEW ZEALAND COLLEGE OF MIDWIVES AND MINISTRY OF HEALTH 6 APRIL 2018

To: Hon Dr David Clark, Minister of Health

Purpose

This aide memoire is being provided to report on the ongoing discussions with the Ministry of Health (the Ministry) and the New Zealand College of Midwives (the College) on the settlement of the mediated agreement between the parties regarding the sustainability of community-based lead maternity care (LMC) midwives.

Key points

- The Acting Director-General of Health, Stephen McKernan, met the President of the College, Deb Pittam and Karen Guilliland the Chief Executive on Friday 6 April 2018 to continue discussions to find solutions to address the urgent need for a sustainable way of working for community-based midwives.
- This followed on from the March meeting with the College.
- Also attending the meeting were Keriana Brooking, Deputy Director of Service Commissioning and Bronwen Pelvin, Principal Advisor, Maternity from Protection, Regulation and Assurance.
- The Ministry and the College discussed the components of the proposed package put forward for funding in Budget 18. No actual financials were discussed with the College.
- The components discussed were:
  - a recognition of an uplift in the prices of fees
  - additional funding for the provision of a second midwife at births attended by community-based midwives
  - a sum of money to assist individual community-based midwives to maintain and improve quality services to individual women, babies and whanau.
- The College understands that none of these proposals can be discussed further or shared with its membership until Budget announcements are made. They indicated their comfort with the components as the first step in stabilising the community-based midwifery workforce.
- They also understood that no decisions have been made regarding which modules in the Notice the increases will be applied to nor how the Ministry will distribute other funding.
- As soon as the Ministry knows the date of Budget Vote Health announcements, it will immediately reconvene with the College to begin planning the implementation of the maternity components.
- The parties have agreed to undertake a rapid collaboration on a maternity work programme that will ensure improved access to safe, integrated, high quality services that meet the needs of women and their whanau and recognises the value of midwifery.
- The Ministry is convening a DHB maternity leadership group to work closely with the Ministry, the College and other maternity stakeholders including service users.

Contacts:	Keriana Brooking, Deputy Director, Service Commissioning	s 9(2)(a)
	Bronwen Pelvin, Principal Advisor Maternity, Quality Assurance and Safety, Protection, Regulation and Assurance	s 9(2)(a)

- The Ministry agreed to work on a new Memorandum of Understanding with the College to improve the ongoing collaboration that is being developed through the process of engagement.
- A media release was sent to the media at midday on 11 April and is appended to this aide memoire.
- A Weekly Report item will be prepared for Associate Minister Genter.

Recommendations

The Ministry recommends that you:

This report is for your information only and does not request any decisions.

Keriana Brooking
Deputy Director
Service Commissioning

Minister's signature:

Date:

Appendix One

Media release

11 April 2018

The Ministry of Health and the New Zealand College of Midwives are working together with urgency on a maternity programme designed to address current pressure on the midwifery-led service.

Acting Director-General Stephen McKernan acknowledges collaboration over the last month between the College and Ministry officials has resulted in a positive way forward.

"Addressing workforce shortages and collaborating on a maternity programme that delivers a sustainable midwifery model of care has guided discussions.

"The Ministry has taken on board advice from the College to include elements of the co-design process.

"As a result the Ministry has agreed to develop a Memorandum of Understanding with the College to improve ongoing collaboration on the maternity work programme," says Mr McKernan.

New Zealand College of Midwives, Chief Executive Karen Guilliland says women, their babies and families need improved access to safe, integrated, high quality services.

"The College and the Ministry agree a midwifery continuity of care model must be resourced effectively to provide support during pregnancy, labour and birth and through the postnatal period until the baby is six week old.

"I am also pleased that the issues raised by the current workforce shortage will be prioritised for resolution; for example, continuing to provide rural primary maternity service provision in all areas," says Ms Guilliland.

END.