The strategic direction of maternity care in New Zealand

Claire Austin, CEO of the RNZCGP

1. Introduction

1.1 This paper provides an overview about the current position of maternity health care in New Zealand. It raises a series of questions about the lack of strategic direction of maternity services, the current approach to purchase of maternity care and the future sustainability and development of a primary maternity workforce that is appropriate to meet the needs of New Zealand women.

1.2 The adoption of a strategic and cohesive approach to maternity care is critical and significantly overdue. This paper examines the 1999 National Health Committee (NHC) Maternity Review's original findings and draft recommendations for maternity services in New Zealand to the then Minister of Health, Wyatt Creech, in July 1999, obtained under section 12 of The Official Information Act 1982.

1.3 Examination of the original findings of the 1999 NHC Maternity Review, the final report and the current position of maternity services indicates that there are significant anomalies between the original findings of the committee in July of 1999 and its final report in September. This does raise the question as to why there was such a significant departure from the original findings and a loss of a series of recommendations of the review.

1.4 This also raises the question as to whether, in recent times, there has been adequate information provided at high level to facilitate fully-informed and robust strategic decisions on the future of maternity care in New Zealand. It is also concerning that despite information and advice provided two years ago, the same concerns continue to be raised by consumers and providers.

1.5 This paper does not comment on the various merits and different approaches of maternity care providers. It attempts to examine the environment within which providers currently have to operate. It is based on the premise that all health professionals providing maternity services bring a whole range of differing skills, expertise and experience that can contribute positively to the provision of maternity care in New Zealand.

2. Executive summary

Key strategic issues for maternity care in New Zealand

There is a question of whether there has been adequate policy and strategic information available to assist high-level decisions on the direction of maternity care in recent years.

There appears to have been a significant departure from the original recommendations of the 1999 National Health Committee Maternity Review's original findings in July 1999 and the final September 1999 report - Review of Maternity Services in New Zealand.

There is an ongoing absence of a national strategic framework for the purchase and provision of maternity care in New Zealand creating a range of serious strategic risks which will ultimately impact upon the provision of accessible, quality maternity care for New Zealand women, namely:

- reduced choice for New Zealand women seeking maternity services
- an increasingly fragile workforce, threatening the provision of an acceptable range of services to meet the range of needs of New Zealand women
- in New Zealand's social, cultural and geographically diverse society, a 'one-size fits all' approach to maternity care is not appropriate
- a growing loss of local medical back-up in maternity health care, especially in rural areas.

Recent contracts management and purchasing mechanisms have lacked strategic direction, been both ad hoc and inadequately planned.

It is critical that purchasing approaches to maternity services are flexible, women-centred and focused upon outcomes rather than prescriptive delivery models.

It is also essential that purchasing fosters co-ordination and collaboration in maternity health services. Direct contracts to organisations providing comprehensive maternity services should be retained.

Both providers and consumers of maternity care operate within an environment of uncertainty. There needs to be leadership that signals the future direction of maternity services in New Zealand in order for both women and providers to make informed decisions about the future.

A National Maternity Framework should be considered a high priority and developed as soon as practicable – engaging consumers, providers, funders and policy makers to inform the future planning, purchase and strategic direction of maternity care in New Zealand.

(The capacity and resource capability of the Ministry of Health to provide such a framework needs immediate attention).

A National Maternity Framework would need to incorporate a systematic approach to continuous quality improvement in maternity care.

3. The New Zealand Health Strategy

3.1 The New Zealand Health Strategy notes that a wide range of providers deliver primary health care and that in order 'to achieve the aims of the Strategy, it will be important to increase co-ordination between these providers and between primary health care providers and public health and secondary service providers.' (2000:20) The New Zealand Health Strategy also states that 'competition between providers or professional groups has inhibited the development of services oriented to the needs of individuals and communities.' (2000:27) It could be argued that this statement also reflects the current state of maternity health care in New Zealand.

3.2 It is critical, however, to go beyond the tensions between the various providers of maternity care and examine the strategic environment within which providers are expected to operate. This ultimately impacts upon the provision of quality, accessibility and availability of maternity services to New Zealand women. The New Zealand Health Strategy notes the importance of collaboration and co-ordination between providers (2000:9) however, current and proposed purchasing mechanisms do not foster such collaboration, but focus upon a single lead maternity carer as a focus for purchase of services.

3.3 It is recognised that there are limited fiscal resources available for funding of health care and that there is a current inequity of funding of contracts for maternity services throughout New Zealand. However it is noted that an extra $3.7m has been allocated in the 2001 Budget for maternity care; this includes to 'help Maori and rural women with additional antenatal needs' as well as to 'help stabilize aspects of the maternity workforce.'[1] Unless the funding approaches to maternity health care encourage a cohesive, flexible and strategic approach, the maternity workforce will continue to become increasingly more fragile and fragmented, with limited ability of practitioners to provide additional services.

4. Quality as a systems issue

4.1 The current section 88 Maternity Notice does not address issues of quality beyond the individual practitioner. This ignores the importance of the quality environment, one that is systems based. At a recent workshop on quality in general practice held in Wellington, Dr Donald Berwick, CEO of the Institute of Healthcare Improvement noted 'quality was a strategic necessity' which needed a systems approach. His 'Core Principles for Managing Quality' have considerable relevance to the purchase and provision of maternity care in New Zealand:

4.2 Core Principles for Managing Quality

- Intention to improve
- Focus upon customers
- Focus on process and system
- Proper use of measurement and statistics
- Involvement of everyone
- Continuous testing of changes
- Improving upstream
- Collaboration, valuing inter-dependency
- Key role of leaders.

5. The need for a strategic approach to purchasing and funding of maternity services

5.1 The current approach to funding maternity care, namely the section 88 Maternity Notice, is both prescriptive and rigid. A fresh approach to funding and contracting should provide the opportunity to place New Zealand women's needs as the central focus of the contracting/funding model.

5.2 Funding and contracting of maternity services could also be developed to allow multiple points of entry to services, with a focus upon outcomes and the quality of service provision. This places the women at the centre of quality care which focuses upon her specific needs and fosters a flexibly funded service environment in order to provide comprehensive quality maternity care.

5.3 The original July 1999 Maternity Review briefing paper noted that a lack of HFA resources of less than 2.0 FTE staff 'to plan, monitor and manage maternity care is a significant risk, and the HFA should

[1] Minister of Health - Media Release - Budget 2001. 24 May 2001.

give greater priority to developing its capability to manage and advance maternity care.' This situation has not eased, and given the significance and role of maternity services in New Zealand, the Ministry of Health's capacity to develop a strategic approach to maternity services requires immediate attention.

5.4 Noted below are a few examples of recent initiatives in maternity care purchasing, which it could be argued, demonstrate the need for a much more strategic approach to maternity services.

The section 88 Maternity Notice released in August 2001 proposed that all Specialist (other than GP) consults or 'effecting delivery' services would be provided by hospital services. This was put forward without actually examining the sector's capacity to provide these services, such as:

- How many specialist obstetricians are available through hospital services, what is their current workload, and waiting times?
- What are currently the levels of services being provided in the community?
- Can the Ministry demonstrate that the infrastructure and resources are in place to make this an appropriate option for service delivery?

Whilst this proposal has been successfully challenged, it had the potential to create a great risk to women requiring specialist maternity services being unable to receive timely access to specialist maternity care, through inadequate strategic consideration of the issues.

5.5 The Ministry of Health is proposing that the additional funding currently being paid to non-section 88 providers be managed outside of section 88 and by 'deed of assignment' – which effectively means that the additional money offered by the Ministry to non-section 88 providers has the status of a gift. It is understood that copies of the deed of assignment won't be available until February.

This poses significant risks to non-section 88 providers as the deed is considered a 'gift' that provides no contractual rights to the recipient. Without sighting the deed, it would be unreasonable to expect parties to support an unknown arrangement, which will be reviewed every six months and is viewed as a gift from one party to another. This deed of assignment poses potential risks of inability to plan or provide sustainable services with the possibility of that additional funding being withdrawn after six months. Furthermore, it raises ethical issues around these providers offering services to women with a possibility of being unable to fulfil or sustain care arrangements due to withdrawal of funding.

5.6 Consideration of the proposed section 88 Maternity Notice needs to take into account the other related factors which will have a direct bearing upon the provision of maternity services in New Zealand.

- Section 88 Maternity Notice refers to the referral criteria; these are not yet finalised.
- The proposed funding structure is one that promotes fragmentation rather than integration. Is granting the payee number an adequate response to recognise organisations within the notice?
- There is no attempt to integrate this notice with the primary health care strategy – how does this proposal sit with other funding approaches to primary health care?

5.7 In her forward to *The Primary Health Care Strategy*, in December 2000, the Minister of Health states that 'Doctors, nurses, community health workers and others in primary health care will work together to reduce health inequalities and to address the causes of poor health status.' Furthermore, the Minister noted that high quality care will ensure co-ordination over time and across the different providers needed to deal fragmentation and competition between health providers.

6. Workforce issues: the departure of the GP obstetrician

6.1 An ongoing theme in recent years is the exodus of the General Practitioner Obstetrician (GPOs) from maternity care. Little initiative has been taken to halt this particular trend. Furthermore, as well as departure from the provision of existing services, there will also be the ongoing issue of recruitment as well as retention of general practitioners into obstetrics.

6.2 As stated previously, this paper does not intend to comment on the various merits and different approaches of maternity care providers. It is based on the premise that all health professionals providing maternity services bring a whole range of differing skills, expertise and experience that can contribute positively to the provision of maternity care in New Zealand. However, it is important to note that General Practitioner Obstetricians play a pivotal role in the provision of that maternity care in New Zealand, whether as lead maternity carers or working collaboratively within shared care teams or organisations and are identified by consumers as playing an important role in the provision of maternity care.

6.3 The original July 1999 Maternity Review briefing included the results of a telephone survey conducted with New Zealand women about maternity care. The survey asked women how important it was for them to have the Lead Maternity Carer (LMC) of their choice and asked them to nominate their preferred LMC. 35% chose a different LMC than they actually had received:

- 49% using a hospital midwife, the alternative chosen most often was their family doctor
- Of those using an obstetrics specialist, 37% would have chosen their family doctor.
- 31% of those with a shared arrangement between GP and midwife said that this was not their preferred option, as did 29% of those who used an independent midwife.

The main reasons given for not being able to have their preferred choice of LMC were that their preferred doctor was not available (51%), that specialist care had been required (14%) and/or that the service was unavailable in their area. (12%) (1999: Appendix 1:3)

6.4 The National Council of Women also conducted a survey of Maternity Services in New Zealand in 1998. The report notes 'The choice of LMC appears to be diminished by the apparent unavailability of shared care, and the great reduced numbers of GPs who are delivering. Many women are dissatisfied with the reduced choice. Rural women in particular said their choices were few, as the numbers of available LMCs.'

Furthermore, the report noted that 'evaluation of women's answers and comments throughout the questionnaire indicate inconsistencies in the type and quality of maternity services available to women.' (1998:6)

6.5 The 1999 Maternity Review further noted 'There is a strong view from consumers and providers that the 1996 changes to maternity care have resulted in reduced choices for women, contrary to its intent. This is attributed to the reduction in the number of GPOs providing maternity care; the limited number of independent midwives and pending 'burn-out', the lack of culturally appropriate or 'culturally responsive' services, e.g. Maori midwives; the lack of specialist services in some areas.' (1999: Appendix 1:2), and

'Most consumers who commented on the lack of availability of services, were unhappy at the lack of shared-care arrangements i.e. the ability for a woman to have the involvement of both a doctor and a midwife in her maternity care. This issue is key for GPOs who attribute their declining involvement in maternity care to the competitive environment fostered by the funding model, inadequate levels of funding and burnout for those still involved.' (1999: Appendix 1:2)

6.6 There is also the question of rural women and their ability to access safe, effective rural obstetric services and emergency medical back-up if required. In planning services, it is critical to manage risk. The largest prospective observational study performed on low risk women (The National Birth Centre Study) showed that 8% of these women had a potentially serious complication during labour, delivery or the immediate post-partum period. RNZCGP (1999:34)

6.7 The question still remains as to why ongoing feedback and information about reducing numbers of GPOs in New Zealand appears to have been disregarded, unless a decision has been made about this particular maternity workforce issue and not explicitly communicated to the sector.

7. Workforce issues – sustainability of services

7.1 An issue for the Health Workforce Advisory Committee will be consideration of the existing maternity workforce and its sustainability. Undersupply of one area of the workforce will create existing pressures upon remaining providers.

7.2 The issue of success management lies not only within general practice obstetrics but within midwifery itself and leads to the question of sustainability and viability of maternity services as a whole, a copy of this report will be forwarded the Health Advisory Workforce Committee.

8. The original recommendations of the 1999 National Health Committee Maternity Review, the final report and the direction of maternity care in New Zealand

8.1 Whilst the section 88 Maternity Notice is under consideration, it is an important opportunity to examine current funding approaches for their strengths and weaknesses, to examine where service provision is adding value.

8.2 It is very concerning however, to review information and advice provided by the National Health Committee Maternity to the then Minister of Health, Wyatt Creech, in July 1999, to compare it with the final report taken, and the current state of service provision and ongoing uncertainty within the sector.

The following table identifies key findings and recommendations of the original briefing, the final report and the status of these issues in 2001. The original briefing raised a range of key issues that appear to still be inadequately addressed and if remain so, are poised to severely compromise the future of quality, comprehensive maternity service provision in New Zealand.

Issue	1999 National Health Committee Review (Draft recommendations and key findings)	1999 National Health Committee Review (Final Report)	Current situation
Strategic planning	The development of a *maternity strategy is a high priority* for Government and the HFA (Health Funding Authority) *Lack of any vision or strategic direction* for the provision of maternity services in New Zealand *Lack of HFA resources to plan, monitor and manage* maternity care is a significant risk (<2 FTE staff) The HFA should pursue *innovate (sic) strategies* which provide a value in the provision of maternity care *within a national framework*	All maternity services should be governed by the same set of principles (refer Appendix 1) *Recommendations silent* on need for strategic direction *Recommendations silent* on development of capacity of the HFA	No existing maternity strategy (or under development) No explicit leadership or direction for maternity services - who is taking responsibility for the direction of maternity services? Little opportunity for service development, needs analysis models of care..
Data collection and collation	Better planning and monitoring of services is essential	HFA should pursue an active programme of performance management: Consolidation of perinatal data collection	No current key performance indicators for maternity care that outlines best practice delivery 1st perinatal data due out soon - LMC data only - requires ongoing development
Contracting and purchasing	That the HFA audit, monitor and evaluate services at a national and regional level to *ensure standards of care are consistent with a national framework and principles of provision of maternity care* Perverse incentives of section 51 are not well managed by the HFA 'No one size fits all' arrangement for the purchase of maternity care - but a (national) *framework must ensure that services are purchased in a comprehensive and coherent way* to ensure that there are not gaps in the access choice and quality of care provided Direct contracts for maternity care for provider groups introduces incentives for enhanced and extended care *HFA should develop more direct contracts with organisations and professional groups in future.* Direct contracts should be prioritised based on population needs and benefits or added value to recipients	All maternity services should be governed by the same set of principles *(Silent on national framework)* *Silent on comprehensive approach to purchase of maternity care.* Allow financial accountability under s51 to be held by an entity other than an individual LMC Any new direct contracting arrangements should address identified needs in the community rather than develop in areas which already have adequate maternity services *Only allow those which offer demonstrable added benefit* Evaluate and seek greater consistency among current direct contracts before more developed	*No national framework* Or key performance indicators or criteria developed s88 (ex s51) to be single mechanism for purchasing maternity services - direct contracting arrangements being absorbed into s88 process *Direct contracting arrangements being phased out*

Co-ordination of care	Most consumers commenting on lack of availability of services - unhappy about lack of shared care	Improve integration of primary maternity care through increased use of single service episodes of primary health care	Proposal to fund general practice single services from alternate sources, GMS and patient fees
Workforce issues	Strong consumer view re: lack of choice attributed to reduction of number of GPOs providing maternity care Lack of culturally appropriate or responsive services e.g. Maori midwives Lack of specialist services in some areas Recruitment and retention Lack of GPOs - rural areas	Acknowledges large numbers of GPOs have ceased to provide maternity services - notes it doesn't have the mandate to reverse the changing makeup of the workforce Raises lack of choice for women who want a GPO as lead maternity carer and doubts about the sustainability of the maternity workforce Recommendations note MOH and HFA *must expedite the development of a primary maternity workforce that is appropriate to the needs of NZ women.*	Ongoing departure of GPOs from maternity services *HWAC - are they checking this one?*
Quality of care	Principles of best practice should be reflected in provision of maternity care in New Zealand. HFA audit, monitor and evaluate services at a national and regional level to ensure standards of care consistent with the national framework, principles and standards of the provisions of care HFA set up maternal and perinatal review committee to monitor and manage national data on: • Mortality • 'Near-misses'	*Principle x: Maternity services should be delivered within the broader context of quality health care; LMC must be part of a health care network.* Access agreements, provider audit - benefit claiming, record keeping, care plans	Addressed solely through the sec 88 notice - individual practitioner No existing methods of gathering of data which informs quality, safety and service delivery, development *Information* *Safety issues* *Mortality data about to be reported* *Near misses not included*
Involvement of consumers	Participate in the planning and development of maternity care at a national and locality level funded by the HFA National Advisory Group Locality based Maternity Services Liaison	*Principle xi Maternity services should involve women as consumers in the planning and monitoring of maternity care*	National Advisory Group (mixed with providers) No national advisory consumer group Various local groups commenting on s88 notice

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