Co-designing the funding model for community LMC midwives

How did we get here?

- **August 2015** - High court case taken by the College for pay discrimination on the basis of gender. Just days prior to case being heard, in August 2016, the Ministry of Health offered mediation

Mediation outcomes:

- Interim 2.5% pay rise backdated to 1 July 2016 and a further 6% pay rise from 1 July 2017
- Unspent funds from MFYP contract (with less graduates than forecast) to be used for urgent urban locum relief, antenatal travel and more rural support
- The Ministry of Health and the College engage in a co-design process to develop a new funding model for LMC midwives. This includes:
  - an independent evaluation of the role of and appropriate remuneration for the work of community LMCs
  - using the governments pay equity principles, to ensure gender discrimination is eliminated and taking cognisance of historic and systemic under valuation
- A budget bid for 2018 to implement a new funding model

No longer in mediation, we can now openly consult on the funding model with members.

Co-design process:

The team

**NZCOM:** Karen Guilliland, CE, Alison Eddy, NZCOM Midwifery Advisor, Deb Pittam, President, Nicole Pihema, LMC midwife Northland, NZCOM Northland regional chairperson and member of the NZCOM mediation team member, Violet Clapham, LMC midwife Canterbury, NZCOM Canterbury West Coast regional chairperson and NZCOM mediation team member, Wayne Robertson, NZCOM Accountant and Business analyst with extensive experience in private sector and Carla Martin – NZCOM finances (Masters of Accountancy student) and former MSR Consumer Reviewer.

**Ministry of Health:** Bronwen Pelvin, Principal Advisor Maternity & midwife, Laura Ross, Principal Advisor Maternity Operations Policy, Nathan Clarke, Policy Analyst, Tracey Moore – Project manager

**Consumers (as appointed by MoH):** Rose Swindells, Wellington and Jeanine Tamati-Elliffe, Christchurch, both of whom are members of the National Maternity Monitoring Group.

**Facilitators:** Thinkplace, [http://www.thinkplace.co.nz/company/who-we-are](http://www.thinkplace.co.nz/company/who-we-are)
Co-design timeline

- **March – April 2017**: Preliminary Co-Design Team meetings
- **May – July 2017**: Four Co-Design Team Meetings with facilitators
- **July 2017**: appointment of expert job evaluator
- **August 2017**: NZCOM National Committee Meeting
- **November 2017**: 2018 budget bid deadline
- **July/August 2018**: Implementation with yearly reviews thereafter
- **On-going**: Consultation throughout design

It is tight! We need to get fix how much midwives are paid as quickly as possible and the new co-designed funding model offers us the opportunity to achieve pay equity. We intend to achieve the ability to review and refine the model over time.

**Important**: it is a new funding model that is being developed, NOT a new model of care. There is no intention to change the LMC model of care but we need to be mindful how changes in funding may impact on it.

Designing a new funding model

The issues with Section 88 have been well researched for the court case and this information has been used to inform the co-design process so the same issues are not repeated. We have also done a lot of work looking at all of the costs that need to be covered by a new funding model. This includes both your time, including on-call and non-clinical work, sick leave and annual leave as well as your business costs including travel, equipment, clinic rents, professional fees, recertification, phones...). We have also researched international funding models for community midwifery.

Your ideas

There will be opportunities to comment further as options are developed, but at this stage we need some feedback from midwives on some broad questions in relation to two key areas being, **how do midwives want to be paid and what for? And, who should pay midwives?**

1) **Employed or self-employed?** LMCs are predominately self-employed, with this comes professional autonomy and the ability to provide a women centred, flexible service. However is also comes with some challenges. What are the pros and cons of employment vs self-employment? Which option do midwives predominantly prefer? Which option would support the model of care best?

2) **If employed, who would employ midwives?**

3) **If self-employed, how do midwives want to be paid?**

We understand the current funding under Section 88 does not remunerate sufficiently for all the costs of self-employment including leave entitlements. Any new funding model would aim to rectify this.

- **a) Fee for services with modular payments?** Section 88 is a modular fee for service payment method. Although there are flaws in the payment rules, including the amounts and timing of payments, it is a relatively simple contract. Would an improved Section 88 type contract be acceptable? Is there some
merit in separating the business costs out so that they are explicit and noted separately from the payments for the services provided and potentially, providing a better negotiating base in the future.

b) **Advance payments with a ‘wash up’?** Would midwives prefer to be paid regular amounts through the year, based on an estimated caseload and then potentially owe money at the end of the year if they don’t complete the care (or be paid more if they provide more care)? This system could be developed so that there were more regular checks and balances throughout the year so midwives didn’t end up being owed or having to pay back large amounts of money at the end of the year.

c) **Or a Mixed method?** With some aspects (business costs) being paid in regular instalments through the year and fees for services provided to booked women paid as services are provided?

d) **As group practices or individuals?** Is there value in some of the payments (business costs) being collectively paid to midwifery practices (rather than individuals) so that you can achieve economies of scale by pooling some expenses (e.g. admin support, clinic rent, phone contracts, claims management, rescheduling clinics...). What would be the advantages / disadvantages of this approach?

e) **What about an ‘experience’ fee?** Should LMC midwives be paid on an increasing scale for their work (like employed midwives in the MECA), with a higher amount / salary that recognises experience up to 6 years (for example)?

f) **How should the extra work that women with greater than needs be acknowledged within payments?** Some women require more time / travel than others. How should this be remunerated? What criteria should be used to determine what is “straight-forward” vs “not straightforward”, without creating perverse incentives or medicalising women (i.e. incentivising activities that would make women receive more interventions than necessary)?

4) **Who should pay midwives?**

At the moment, each LMC has a contract held with the Ministry of Health. The Ministry have signalled that they may not be keen to continue with this arrangement and they would rather devolve the funding. If not the Ministry, who should administer the funding for community LMC midwives?

a) A single national maternity provider who could disburse funding to individuals or practices? (This organisation could also provide structural supports like funded locum services, IT support, business management support and so on). The College’s view is that there are significant risks in the budget being managed by PHOs or DHBs and a single national provider is a preferable option as it ensures the integrity of the maternity service and the model of care.

b) **DHBs?**

c) **PHOs?**

The co-design team welcomes your thoughts and feedback. There will be more regional meetings throughout the year, as well as member surveys as the new model is developed.

To contact us with your views and thoughts please email: codesign@nzom.org.nz