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Dr Pat Tuohy
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Child and Youth Health
Ministry of Health
Box 5013
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Dear Dr Tuohy

Submission on proposed Section 88 Notice for Primary Maternity Services

Thank you for the opportunity to comment on the proposed changes to the Section 88 Notice for Primary Maternity Services.

The New Zealand Rural General Practice Network (the Network) has consulted with rural general practitioners and nurses providing maternity care. We identify below some aspects of the proposed changes with which we are in agreement. We also identify a number of concerns and include suggestions based on the practical realities of delivering maternity care to rural communities.

We are supportive of the formalisation of transfer of care between providers and the clarification of who has responsibility for care. We are also supportive of the formalisation of discharge requirements and information being provided to well child and primary health services during and following the post-natal period. We also agree with the proposal to separate referral guidelines and access agreements from the Maternity Notice so that these may be amended accordingly.

Specific comments relating to the Proposal for Consultation – Primary Maternity Services Notice 2007

The New Zealand Rural General Practice Network does not believe that issues specific for rural women have been adequately addressed in this notice. Furthermore we believe that this Notice falls woefully short of adequately identifying or addressing the ongoing problems of maternity care in New Zealand.

The Network believes that the open and transparent consultation sector wide is a fundamental and necessary first step. To date the Ministry has not tackled the 'glass ceiling' for change, permitting much of the debate (or consultation) to occur within carefully maintained and defensive silos.

In preparing this response the Network is aware of the NZMA's response, which focused on issues of serious concern. The Network fully supports the submission of the NZMA and within this response has chosen to focus on issues as highlighted by our rural GP and nurse members.

Response by section :

A10 (4) *We believe this may have been an error* - Ten working days should be twenty working days/four weeks for consistency with the rest of the document. Twenty working days allows adequate time for response.

B5(b) p15 Definitions – away from usual place of residence. We believe this statement should mean just this and not have defined limits such as one hour or stayed away one night. For instance, a woman could start haemorrhaging and although her hometown is 30 minutes away it would be totally inappropriate to send her back home for care. Additionally, a woman visiting Kerikeri from Auckland may present on her day of travel having not stayed away yet for one or more nights – again it would be inappropriate to send her back to Auckland for care without assessing her.

Care could be either:

- a. Routine (non-urgent) – provided when staying at least one hour away from usual place of residence and where a person has stayed away for more than one night, such as a holiday, etc.
- b. Non-routine (urgent) when time/distance parameters are irrelevant.

The Network strongly believes that payment must be available to practitioners providing a consultation to women away from their usual place of residence.

CB2 Audit (2) p.26 Immediate access where fraud is suspected is reasonable but otherwise for routine audit ten working days or as soon as reasonably practicable would seem more appropriate.

CB4p.27 “Will” implies a guaranteed outcome, which is not possible. “Strive to” or “aim to” is more appropriate.

CB11 (2) p.29 This could affect locums, especially as the largest proportion of rural locums are from overseas. Locums should have appropriate experience/qualifications. However participation in a PRP may not be practicable for short-term overseas locums and if maternity care were part of the practice this could prove a barrier to rural GPs obtaining a locum.

CB13 (5) p.30 It is odd to specify that referrals to specialists should be in written hard copy especially when many GPs use email referral via Healthlink. Referrals should be provided in a timely and appropriate manner and the medium that is used is irrelevant and should be left to the individual practitioner to decide.

CC8 (1) It is unclear why HealthPAC has chosen 22 working days – is this current standard practice?

DA10 (3) p.37 The maternity provider should facilitate contact between the woman and a local primary healthcare provider – usually a GP and not the PHO. There is an option for GPs not to be part of a PHO and this option should be considered within the notice.

DA19 p.40 This does not specify that the LMC should inform the woman of options for care, which is something that was required in the past but appears to a large extent not done. It is our belief that women have a right to be fully informed of all the options for care available to them and their baby, as such the Network would strongly recommend that this advice be reinstated as a requirement of the LMC, including informing the women of standard advice on Immunisation. We are aware that some women have been actively discouraged from immunizing their babies.

DA 23 (2 and 3) The LMC is required to have another provider to be available to attend the birth at a homebirth or at a birthing unit. However, only one labour and birth fee is claimable. The Network would recommend the second provider is also paid an equivalent fee under the “homebirth supplies and support” or “birthing unit support” fee.

DB10 p.52 It is not clear by the following statement: “the PHO practice with whom the woman is enrolled” – whoever the non LMC provider is should have to provide the appropriate services and this could well be someone other than a provider who works for the enrolled woman’s PHO.

DB14 (2) p.54 Why can these fees not be claimed by an enrolling PHO? It is assumed there is no funding under capitation for urgent pregnancy care, therefore the provider of urgent care, whether it be a GP, midwife, PHO or other provider should be able to claim the fee.

The fees

We believe that the Ministry does not pay an appropriate level of fees and that these need to be reviewed and comment as follows.

Specific comments

1. The modular payment for non-LMC first trimester services is more appropriate.
2. Non-LMC urgent normal hours – this fee is less than GPs would charge for a normal casual consultation and is therefore wholly inadequate. The fact it is urgent also implies it is likely to be more complex.
3. Non-LMC urgent out of hours. As above, but there is additional traveling time and cost to travel from home to surgery and then to the patient. For example, a GP makes a 40km round trip @ \$1.00/km = \$40. Therefore, without taking into account time and expertise the fee is already reduced to \$15 – not a good reward for the time and expertise expended.
4. It is pleasing to see that the ability of a GP to claim as a non-LMC helping a rural LMC has been retained. Re non-LMC labour and birth – this fee may be appropriate but if a GP has to accompany a woman away from the area, especially in rural/remote areas, this may take many hours in which case the fee is again inappropriate.
5. Non-LMC urgent post-natal care – see point 2 above.
6. The document also states that non-LMC providers “must” provide services and these must be provided free of charge to persons who are eligible to receive them. In some cases, especially with haemorrhage there may be a significant amount of equipment consumed such as IV equipment, oxygen, swabs, gowns, etc and there is no mechanism to recoup this cost.

7. There needs to be a mechanism to either pass additional costs onto the patient or, preferably, be able to invoice MoH/HealthPAC for additional time, services and equipment in exceptional circumstances as is allowed under the current maternity agreement. In this case a brief written supporting document would be required without making the claiming process too onerous or likely to rejection of a reasonable claim.
8. A GP noted in her submission that they “do mostly antenatal care prior to 16 weeks. Having the practice, as a provider would be excellent – assuming this means practice nurses can be providers. Currently antenatal care is free if you see a GP, but charged if you see a practice nurse”.
9. There needs to be more flexibility in the claiming and referral guidelines. Some women refuse midwife enrolment – which basically means they can't access scans as GPs can't refer them for a scan after 16 weeks

The Network strongly supports the Name's comments in regards to funding.

General points

The Network has concerns about accessibility and choice for women who wish to have their general practitioner involved in their antenatal care or to at least have this option available to them. We believe that more needs to be done to facilitate women accessing this option.

We are of the view that a shared method of care is the preference of most GPs with involvement throughout the pregnancy and post-natal period (and for the very few who have involvement in intrapartum care).

Finally we also suggest that throughout the document the “PHOs” should be replaced by “GP/provider” where appropriate.

We are happy to provide further information in support of this submission.

Yours sincerely

Adrienne Steele
Chief Executive