

Health Policy: Maternity Care

More choice for mothers. A better start for families.

INTRODUCTION

As we face more challenging economic circumstances, it is as important as ever to ensure that the very youngest New Zealanders get the very best start in life.

Maternity care is in crisis.¹ In many parts of the country there is a chronic shortage of midwives, pregnant women cannot choose a Lead Maternity Carer (LMC), and there is no choice in birthing facilities.

GPs, LMCs, and providers of postnatal care often do not communicate enough. Too many new mothers are pressured into going home before they are ready, and many who are at risk are not getting the extra help they need. This must change.

National will improve maternity services to provide safe high-quality care for pregnant women, mothers, and their babies.

We want to ensure that all women and their families have:

- More choice in Lead Maternity Carers.
- Improved continuity of care through pregnancy.
- Better choice of birthing facilities and the option to stay longer.
- Better postnatal support.

To reach these goals, National will make the most of existing resources. We will also provide new investment to boost the maternity workforce, help at-risk mothers, give new mothers the opportunity to stay longer in birthing facilities and get more support, and increase the number of postnatal visits.

This investment will be funded from within the indicative health spending allocations in the 2008 Pre-Election Fiscal Update.²

¹ See "The Maternity Workforce Crisis" in the Background to this policy.

² See National's Health Policy [Funding and Framework](#).

BOOSTING THE MATERNITY CARE WORKFORCE

National believes that every mother-to-be should have a choice of LMC. They should also have confidence that during their pregnancy they will be safe and will receive high-quality maternity care. To help achieve these goals, we need more skilled midwives, GPs, and obstetricians to be there when women need them.

National wants to encourage more people to pursue a career in midwifery, and encourage midwives who have left the profession to return.

We will establish a voluntary bonding scheme for graduate midwives. New midwives who agree to work in hard-to-staff areas for three to five years after graduation will receive student loan write-offs. For more details of this policy see our [Voluntary Bonding Scheme](#).

Under a National Government, a new midwife who joins the scheme with a \$30,000 student loan will be debt free after five years as a result of government write-offs and their own loan repayments.

National wants to encourage GPs who have stopped practising obstetrics or who are interested in specialising in the field to play a greater role in maternity care.

We will offer increased subsidies for retraining and refresher courses for experienced GPs who have a postgraduate Diploma of Obstetrics and Medical Gynaecology (or equivalent) and who want to return to providing maternity care for women and their babies in the antenatal and postnatal periods. Some GPs may also be willing to return to delivering babies. We estimate this will cost about \$300,000 a year.

We will also encourage younger GPs to undertake the Diploma of Obstetrics and Medical Gynaecology.

National will offer greater support for all maternity-care professionals and greater engagement with district health boards (DHBs). We will encourage the development of clinical networks across regions to assist in the planning, delivery, and improvement of maternity care. These networks will involve LMCs, GPs, mothers, and non-government organisations such as Plunket.

We will expect DHBs to follow the recommendations of the recent Review of Maternity Services at Wellington Hospital, and ensure that all maternity-care professionals in their districts collaborate to develop best-practice procedures.

Care around the time of delivery is a team effort based on a wider support network. To assist the team to function better, the wider network needs to be better integrated. This will help reduce professional isolation.

National will:

- Establish a voluntary bonding scheme that writes off student loan debt for graduate midwives who agree to work in hard-to-staff areas for three to five years.
- Subsidise retraining and refresher courses for GPs who have a postgraduate Diploma of Obstetrics and Medical Gynaecology (or equivalent), and who want to resume providing maternity care.
- Encourage clinical networks across regions to assist in the planning, delivery, and improvement of maternity care.

ENHANCING CONTINUITY OF CARE FOR AT-RISK MOTHERS

National believes that some at-risk mothers are not getting enough support through the maternity-care system.

To ensure that the needs of these mothers are met, we want GPs and LMCs to work together more closely during the pregnancy to identify how they can provide positive outcomes by matching their separate and complimentary skills. This will improve continuity of care by ensuring, for example, that the health history of an at-risk mother will be better understood by everyone involved and that appropriate planning occurs.

National will fund an optional meeting each trimester for at-risk mothers so they can discuss their care plan with their LMC and their GP together. Mothers will be able to access these meetings if they, their GP, or their LMC believe their circumstances place the mother or child at risk.

We estimate the cost of this policy will be \$1.5 million a year.

National will:

- Fund an optional meeting each trimester for at-risk mothers so they can discuss their care plan with their LMC and their GP together.

IMPROVING BIRTHING CHOICE AND CONFIDENCE

A lack of choice in birthing facilities³, midwife shortages, and staff shortages are contributing to shorter stays in birthing facilities, and greater pressure is being put on new mothers to leave before they are ready.

Many of these women are not adequately prepared for the challenges of parenting.⁴

National believes that women should have the opportunity to choose from a range of safe birthing options – and the opportunity to give birth in a facility that is as close to home as appropriate.

Some DHBs already provide a choice of birthing facilities and we will work with other DHBs to encourage such choices to be provided more widely.

National will ensure that new mothers may stay in a birthing unit longer so they can establish breastfeeding and the confidence to return home. This means DHBs have to expand birthing facility options to ensure that mothers and their babies are safe and healthy.

We will provide an extra \$11 million a year so new mothers can stay longer in birthing facilities and have better access to breastfeeding support.

National will:

- Work with DHBs to provide greater choice in birthing facilities.
- Ensure mothers have the choice to stay in birthing facilities longer so they can establish breastfeeding and the confidence to return home.
- Boost funding for postnatal care by \$11 million a year so that new mothers can stay longer in birthing facilities and have better access to breastfeeding support.

³ Birthing facilities include not only hospitals but also primary maternity facilities.

⁴ See “New Mothers Pressured to Leave Hospital before They are Ready” in the Background to this policy.

BOOSTING POSTNATAL SUPPORT

New mothers should have confidence that the support they receive in the first months after birth is high quality and provided in a timely manner. There should also be a seamless handover between the LMC and WellChild⁵ services (such as Plunket) to ensure that there is good continuity of care.

National wants to ensure that every new mother can have weekly contact with a health professional for the first nine weeks of their baby's life.

In the first six weeks, mothers are entitled to seven visits from their LMC before the LMC hands over care to WellChild providers. Many mothers are missing out on this full entitlement because of midwifery shortages and poor integration or handover.

National will maintain LMC visits at present levels and boost the number of funded WellChild visits from two to five between the 4th and 9th week to ensure there is better continuity of care during the handover to WellChild, and greater support for new mums if they need it.

The table below describes National's boost in WellChild visits.

Table 1 – Funded WellChild Visits for Newborns in the First Nine Weeks

WellChild Visits	Current Policy	National's Policy
Week 4	1	1
Week 5		1
Week 6		1
Week 7	1	1
Week 8		1
Week 9		1
Total Visits	2	5

⁵ WellChild is the Ministry of Health funded framework for screening, education, and support services for New Zealand children from birth to five years, and their families. See "WellChild Care" in the Background to this policy.

We estimate the cost of this policy will be about \$13 million a year.

We also want to ensure that new mothers will continue to get additional support through Plunketline.

Before the 1999 election, Labour pledged to fully fund a 24-hour Plunketline, but the Prime Minister has broken that promise. Plunket has subsequently self-funded a 7am-midnight service.

National will fully fund Plunketline to provide a 24-hour service, at a cost of about \$3 million a year.

National will:

- Ensure every new mother and baby has a weekly visit with their LMC or WellChild provider for the first nine weeks of their baby's life. More visits will provide greater breastfeeding support and boost confidence.
- Fully fund Plunketline to provide a 24-hour service.

Background: Maternity Care

THE MATERNITY WORKFORCE CRISIS

Midwifery is currently suffering a severe workforce shortage nationwide. Fifteen out of 21 DHBs report shortages and about 4,000 mothers are unable to choose their LMC. Counties Manukau DHB, for example, says it is approximately 80 midwife LMCs short.⁶ Mothers who cannot find an LMC attend midwife consultations at hospitals and this offers no continuity of care.

Research shows continuity of care improves outcomes for mothers and children.⁷ In addition, some midwives are handing over to WellChild providers at two weeks, well short of the six weeks required, because of high workloads. New Zealand is no longer self-sufficient in educating midwives and relies on importing foreign-trained midwives.

NEW MOTHERS PRESSURED TO LEAVE HOSPITAL BEFORE THEY ARE READY

There have been several high-profile incidents raising concerns over mothers leaving hospital too soon following birth. In November 2007 Capital and Coast DHB offered \$100 supermarket vouchers to mothers leaving hospital within six hours of birth.⁸ This was withdrawn after public outcry.

Women from around the country tell National that they perceive pressure to leave before they are confident to return home. The average length of stay for mothers in hospitals is 2.9 days.⁹

⁶ Responses to Official Information Act requests.

⁷ Hodnett ED, "Continuity of caregivers for care during pregnancy and childbirth", Cochrane Database of Systematic Reviews (Issue 1, 2000), page 3.

⁸ "Baby bribe a heartless, cruel move", NZ Herald, 30 November 2007.

⁹ Hon Steve Chadwick, press release, 9 May 2008.

WELLCHILD CARE

People remember the Plunket "tradition" which provided seemingly unlimited care to new mothers. Today, Plunket and other WellChild providers are overstretched non-government organisations. Plunket nurses frequently have limited time to follow up on missed appointments.

Under the current WellChild schedule, eight health checks are offered to children from 4-6 weeks to three years.

The frequency of postnatal visits is often not adequate and the handover to WellChild at six weeks can be put under stress. In addition, many at-risk mothers and families are not getting any services and many do not get the extra help they need.