What Models of Maternity Care Do Pregnant Women in Ireland Want?

Abstract:

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Abstract

The introduction of new models of care in the Irish maternity services has been recommended by both advocacy groups and strategic reports. Yet there is a dearth of information about what models of care pregnant women want. We surveyed women in early pregnancy who were attending a large Dublin maternity hospital. Demographic and clinical details were recorded from the hospital chart. Of the 501 women, 351 (70%) (352 (70.3%) of women wanted shared antenatal care between their family doctor and either a hospital doctor or midwife. 228 (45.5%) preferred to have their baby delivered in a doctor-led unit, while 215 (42.9%) preferred a midwifery-led unit. Of those 215 (42.9%), 118 (55%) met criteria for suitability. There was minimal demand (1.6%) for home births. Choice was influenced by whether the woman was attending for private care or not. Safety is the most important factor for women when choosing the type of maternity care they want. Pregnant women want a wide range of choices when it comes to models of maternity care. Their choice is strongly influenced by safety considerations, and will be determined in part by risk assessment.

Introduction

The organisation of the maternity services in Ireland is the subject of widespread discussion at present. ¹⁻⁵ There are concerns about clinical safety and quality, despite the fact that Ireland has one of the lowest maternal mortality rates in the world. There are concerns about the cost of obstetric negligence claims, while the national caesarean section rate continues to escalate. There are misgivings about hospital facilities and it has been accepted that at least four large maternity hospitals need to be relocated on to the site of a general hospital. ³ There are concerns about the number and experience of midwifery and medical staff in the future with an ongoing dependence on overseas recruitment at the expense of less developed countries. There are considerable variations of clinical practice between hospitals and, perhaps, within hospitals. There are arguments in favour of rationalisation and the centralisation of maternity and neonatal services and, at the same time, a desire to bring services closer to the women in the community.

As part of these discussions, there have been calls for new models of maternity care and an increase in the availability of choice for all women. ² The Review of Maternity and Gynaecology Services in the Greater Dublin Area, for example, has recommended the creation of midwifery-led units adjacent to hospital-based obstetric units. ³ The Review also recommended the option to have a home birth and the Health Service Executive (HSE) has established a National Taskforce on Home Births. There has been a strong input on models of maternity care from patient and professional advocacy groups. However, there has been a dearth of information about what models of maternity care women in Ireland want themselves. The purpose of this study was to seek the views of women in early pregnancy about the different models of care.

Methods

The Coombe Women and Infants University Hospital is a teaching hospital responsible for delivering between 8,000 and 9,000 mothers annually. About one in eight mothers in the country are delivered in the hospital and they are representative of all socio-economic groups. The women live predominantly in the greater Dublin area and are not confined to any catchment area. In addition to the standard hospital care, the hospital provides an Early Transfer Home service (ETH). It does not, however, provide a home birth service and does not have a midwifery-led unit. Women attending outpatients in early pregnancy were recruited at their convenience in July 2010 (CB). They were asked to complete a short questionnaire about their preference for maternity care. To avoid any risk of bias, no explanation was given before distributing the questionnaire. The women were also asked to rank ten factors that influenced their choice of model of care. Demographic and clinical details were recorded from the hospital chart. Women opting for midwifery-led care were analysed for eligibility according to objective criteria set by the North East Region of the HSE. The data was computerised for subsequent analysis which was undertaken using SPSS version 15.0.

Results

There were 501 questionnaires completed. The women's characteristics are shown in Table 1. Their preferences for the different models of maternity care antepartum, intrapartum and postpartum are shown in Table 2-4. Their preferences for the different models of maternity care antepartum and intrapartum are shown in Table 2 & 3 and factors that influenced choice of maternity care are shown in Table 4. Women's preferences for models of care for delivery were analysed according to whether they opted for private care or not. The majority (70.3%) of women wanted shared antenatal care between their family doctor and either a hospital doctor or midwife. Of the 501, 45.5% preferred to have their baby delivered in a doctor-led unit, while 42.9% preferred a midwifery-led unit. Of those who opted for midwifery-led care, 55% met the criteria for suitability. There was minimal demand (1.6%) for home births. Of the 8 who opted for home delivery, only 4 (0.8% overall) were suitable on clinical grounds. Safety for the baby is the most important factor for women when choosing the type of maternity care they want. A private room and a desire to avoid hospitals are least important. Of women surveyed, 86% believed they had enough information to allow them to choose the model of maternity care.

Discussion

We found that pregnant women in Ireland want a range of choices when it comes to models of maternity care before, during and after labour. Their choice is strongly influenced by childbirth safety issues and least influenced by the physical surroundings for childbirth. Their choice varies but will be determined, in part, by clinical risk assessment. There was minimal demand for home births. As this was a survey conducted in a hospital setting we may have underestimated such a demand. However, we can find no national data for planned home births. In the Eastern Region less than 100 home births take place each year provided by independent community midwives. ⁴ In 2002, 71 grants were paid to women who attended a community midwife. In 2006, there were 32 home births under the auspices of the National Maternity Hospital. Concerns have been expressed about the increased risk of an adverse perinatal outcome following home births. In the Eastern Region, for example, it has been reported that the chance of dying due to intrapartum hypoxia is one in 70 ⁸ after a planned home birth compared with one in 3600 after a hospital birth (p<0.01). In a recent meta-analysis which included English language peer-reviewed publications from developed countries, maternal and newborn outcomes in planned home births were compared with planned hospital births. ⁸ Planned home births were associated with fewer maternal interventions and less frequent prematurity. Although planned home and hospital births had similar perinatal mortality rates, planned home births were associated with a tripling of the neonatal mortality rates.

In the Netherlands, the home birth rate constitutes one third of all births, which is higher than in other developed countries. ^{10,12} However, a number of recent reports have highlighted concerns about maternal and perinatal mortality. ^{12,13} In an audit of maternal morbidity, it was concluded that home birth influenced the outcome of 8.4% of cases. ¹² In Ireland there is a lack of clinical data on the risks or benefits to either the mother or her baby following a planned home birth, which is in sharp contrast to planned hospital births. Further information is also required nationally as to why women opt for home birth rather than a hospital birth. The Greater Dublin Area Review recommended the introduction of midwifery-led units and 42.9% of the women in our study opted for this model as their first choice preference. ³ When clinical risk assessment criteria were applied 20.5% overall of those questioned were suitable for this model of care.

The Greater Dublin Area Review recommended the introduction of midwifery-led units. When clinical risk assessment was applied 47.9% of the women in our study were suitable for this model of care and 23.8% opted it. The results from such a model for low risk pregnancies in the North Eastern Region appear promising. ¹⁴ It is notable, however, that in this midwifery-led model 68% of women were transferred either temporarily or permanently to see an obstetrician antenatally, and 16.8% needed to be transferred temporarily or permanently into the hospital model of care during labour. Importantly, this highlights the interdependency of all models of maternity care and the need for co-location peripartum.

One of the difficulties about the proposals on new models of maternity care is that all models are ill-defined. Furthermore, models that work well in one country may not work well in a different healthcare system. We also have no information on the level of understanding by either service users or service providers of what the different models of care entail. There are no agreed clinical criteria nationally to determine what pregnant women are suitable for what model. There has also been little discussion about how the different models of care will be integrated in the future so that women can move seamlessly between the different models as their clinical circumstances evolve. Finally, it should not be assumed that all 19 maternity hospitals in Ireland need to offer the full range of models of care. Resources and geographic considerations, for example, may influence the range of choices. ¹⁵ The midwifery profession has shown strong leadership in advocating new models of maternity care. ¹⁵ A recent strategic report from the Institute of

Obstetricians and Gynaecologists on the future of maternity services in Ireland has supported enhanced roles for midwifery. There is, however, little information of the views on proposed new models of the professionals who are delivering maternal, anaesthetic and neonatal services under the existing models of care.

It is essential that accurate and detailed information is developed on the risks and benefits on all models of maternity care if women and their families are to make properly informed choices, and if policy decision-makers are to optimise the allocation of limited health resources. Over the next decade, important strategic decisions will have to be made in the Irish maternity services. If our low maternal and perinatal mortality rates nationally are to be maintained, it is imperative that we get these decisions right. Improving information is the key not only to the strategic decisions made by service providers, but also to the personal decisions made by the women using our maternity services. Our study shows that Irish women want a range of choices when it comes to models of maternity care but that safety is their priority. It is the responsibility of those managing the Irish health services to ensure that choices are well-informed, and that choice is delivered in a manner that does not lead to an increase in adverse clinical outcomes.

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