Rural maternity care and health policy

Parents' experiences

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Rural maternity care and health policy: Parents' experiences

ABSTRACT

Objective: To explore rural residents' experiences of access to maternity care with consideration of the policy context.

Design: This paper describes findings from focus groups with parents which formed part of case study data from a larger study.

Setting: Four north Queensland rural towns.

Participants: Thirty-three parents living in one of the four rural towns.

Main outcome measures: Identifying prevalent themes in case studies regarding rural parents' expectations and experiences in accessing maternity care.

Results: Parents desired a local, safe and consistent maternity service. Removing or downgrading rural services introduced new barriers to care for rural residents: (a) increased financial costs; (b) family issues; and (c) safety concerns.

Conclusions: Although concerns about rural residents' health status and health care access have received significant policy attention for over a decade, many of the problems which prompted these policy initiatives remain today. Current policy approaches should be re-evaluated in order to improve rural Australians' access to vital health services such as maternity care.

Keywords: health access; policy; case studies; north Queensland

1. What is already known on this subject?

- Rural Australians have limited access to health services.
- Improving health and access to health services experienced by rural Australians have been foci of government policy for several years.

2. What does this study add?

- A contemporary view of access to maternity services in four north Queensland rural towns.
- Recommendations are made to inform future policies around rural health service provision.

INTRODUCTION

Accessing regular health care during pregnancy, birthing and the postnatal period is a common expectation for Australian families. Yet the location and number of public maternity units over recent years shows a clear trend towards reduced numbers of units and centralisation of services. During 1995-2005, the National Rural Health Alliance estimated 130 rural maternity units had closed across Australia[1]. In Queensland, 43% of public maternity units closed, with the remaining services predominantly located in coastal and more populated locations[2].

Enhancing access to health services for rural residents and improving the health status of rural Australians have been the stated intent of government policies for several years[3]. However, the persisting pattern of maternity unit closures raises important questions regarding rural Australians' access to maternity care. This paper explores the lived experiences of rural families in accessing maternity services. The data are drawn from a broader study investigating health policy and maternity care in rural areas[4]. The design of this broader study acknowledges the need to consider the discourse of government policies alongside the lived experiences of citizens who are most affected by these policies[5].

THE POLICY CONTEXT

There is a distinct absence of policies that specifically address the provision of maternity care in rural settings. Nonetheless, the principles of equity and universalism in health care which underpin large health policies such as Medicare and the Australian Health Care Agreements (AHCAs) should apply to rural maternity care. Contractual obligations of the AHCAs require the states to ensure equitable access to public health services regardless of geographic location[6]. Rural health strategies[7-9] and policy frameworks[10] also contain strong themes of equity of access. Yet, other policy objectives perceivably have a constraining effect on the provision of equitable care. Such constraints include the trend towards centralisation of maternity care (particularly birthing); a concern to provide safe health care and avoid risks; and achieving cost-effectiveness in the health system[11-13].

CASE STUDIES CONTEXT

The findings reported in this paper arise from a broader project comprising four case studies of maternity services provided in four rural north Queensland towns[4]. (Each town was classified as 3-7 on the Rural, Remote and Metropolitan Area classification scale, 1.84–12 on Accessibility/Remoteness Index of Australia and 2.4–15 on the Australian Standard Geographic Classification scale[14].) While this paper focuses on the views, experiences and expectations of rural families as emerged from focus group discussions, data collected in the broader project provided good contextual background and opportunities to triangulate findings.

The case studies revealed that, while all four hospitals worked within the same policy framework, each operated a different type of maternity service:

- Town A had recently ceased birthing services in what had previously been a doctor-led service.
- Town B maintained a model of doctor-led maternity care with a relatively strong roster of proceduralist doctors.
- Town C had a doctor-led service hampered by inconsistent service provision, reflecting variable availability of local proceduralists.
- Town D was trialling a midwife-led model of care.

Each of the units had experienced some downgrading of maternity services; varying from unit closure to the removal of specific aspects of resident antenatal care services (e.g. ultrasound). This required pregnant women to travel to the regional centre for at least some of their maternity care (e.g. ultrasounds, birthing) but sometimes all antenatal and birthing care would be accessed at the regional centre.

METHODS

The methodological approach in this study was based on principles of phenomenology: aiming to gain an insight to the lived experiences of participants in order to explain their reality of accessing maternity care[15, 16].

Sampling

Purposive sampling was used to identify parents with young children as they would have relatively recent experience of accessing maternity care. Parents were recruited via local playgroups that were listed in a phone directory or suggested by local maternity service providers. Participation was voluntary and, liaising through the playgroup organiser, information sheets were provided and appropriate meeting dates, times and venues confirmed. Four focus groups were conducted at the usual playgroup meeting place, while another was held at a participant's home. During focus group discussions, children were nearby playing under supervision of other playgroup parents. Sampling continued concurrently with data analysis.

Focus groups

Semi-structured question guides for focus groups were designed to explore parents' experiences and expectations of accessing maternity care while living in a rural area. A member-checking technique was employed to confirm the investigator's interpretation of participants' responses. Herein, the focus group facilitator would summarise and feed back pertinent points from the discussion at appropriate intervals (usually prior to moving on to a new topic). Further, participants were given the option of receiving their focus group transcript so that they may provide additional comments or corrections where appropriate. Field notes were made both during and immediately following focus groups to assist in providing context for the data analysis.

Analysis

Focus groups were audio-recorded and subsequent transcripts qualitatively analysed using a grounded, iterative thematic technique[17, 18]. The principal investigator completed the majority of coding, although team meetings with all investigators were held regularly to exchange ideas, discuss analysis and emerging themes. These meetings provided opportunity to minimise bias which may be associated with a single researcher. Atlas.ti[19] qualitative research software was used to assist in data analysis.

Ethics

The research team comprised the principal investigator and four other academic staff employed within university health faculties. The team contained extensive experience in research, rural health and health policy. Although some of the team were practicing health clinicians, none were in known

therapeutic relationships with focus group participants. Approval for this study was obtained from the James Cook University Human Research Ethics Committee (H2264, H2453) and all participants completed informed consent forms prior to commencing the focus group.

RESULTS

Thirty-three parents were interviewed over a total of five focus groups across the four sites. Focus groups lasted, on average, 40 minutes (range 28:26 – 53:32 minutes) and no follow-up focus groups were deemed necessary. All but one parent was female, and all had previously experienced accessing maternity care themselves or with their partner. No further demographic data was collected in order to maintain anonymity of participants. Amongst the focus groups was a mix of experiences: some parents had experienced accessing maternity care from a regional centre (including relocation for birthing, termed 'removal'), others had previously received all their care in their hometown, be it rural or urban in nature. This mix of experiences was beneficial in discussing and comparing the options of receiving maternity care in one's hometown and accessing care at a regional centre. Analysis of the focus group transcripts yielded relative saturation of dominant themes which are discussed in more detail below.

Firstly, it is important to note that rural residents indicated a strong preference to attend a local maternity service. Although this was tempered by concerns that services should be safe and consistently available (Box 1).

[Box 1 – preferences for local care]

Secondly, rural residents were faced with increasing financial barriers associated with accessing non-local care, despite public maternity services remaining free at the point of care. At all sites, the downgrading or closure of the local maternity unit necessitated antenatal visits at the regional hospital (particularly for ultrasounds), even for low-risk cases where women may deliver locally. Women who were planning non-local births were expected to relocate to the regional centre two to four weeks prior to

their expected delivery date. The distance to regional hospitals ranged between 70-135kms for the four towns. Residents reported significant costs associated with such lengthy relocation including: (a) return travel; (b) accommodation; (c) food; and (d) lost family income (especially with an accompanying partner). Residents at each of the sites were eligible to access subsidies through the Queensland Health Patient Travel Subsidy Scheme (PTSS) which provides financial assistance for people required to travel more than 50km to approved health services. However, focus group participants indicated that PTSS subsidies cover only a small proportion of their outlay and is poorly advertised with many parents unaware of the program (Box 2).

[Box 2 – financial costs of accessing care]

Thirdly, accessing non-local maternity care, particularly removal for birthing, was associated with a range of family-related issues. Mothers discussed the emotional difficulty of leaving their families and the anxiety associated with being removed from social support networks at such a significant time. For some, the costs of relocation prohibited family members accompanying the pregnant woman, thus leaving her without the very important social and emotional support so valued around the time of birth (Box 3). This was exacerbated by practical considerations of preparing the family, such as organising children's schooling and child care, and negotiating time off work for the woman's partner to attend the birth where possible.

[Box 3 – Family-related issues to accessing care]

Fourth, as local birthing units closed or downgraded, safety became a major concern for parents. While it was routine for women to be told at the regional centre that they should relocate from their hometown two to four weeks prior to their expected due date, many parents reported anxiety and tension about leaving the home and family. Indeed, financial costs compounded by family-related issues caused many to feel they could not relocate weeks prior to birth and instead delayed travelling to the regional

centre until the initial stages of labour. However, participants believed the lack of local facilities increased potential risks, such as those associated with birthing en-route to the regional hospital, or delivery at an ill-equipped local hospital. Parents discussed the implications of being required to transfer to the regional centre and not having sufficient, dependable care available at the local hospital in emergency situations (Box 4). Further, participants were acutely aware of the ever-present dangers of road travel from rural destinations where the only roads connecting the rural and regional towns can be closed in seasonal wet weather and treacherous at night.

[Box 4 – Concerns about safety of care]

DISCUSSION

Rural Australians' health and their access to health services has received years of policy attention[3]. Yet many of the problems which initiated this policy attention appear to remain today. Concerns about rural residents' access to maternity care in particular are not peculiar to north Queensland. Indeed, findings from this study resonate with issues related to maternity service access in other Australian states[20, 21] and elsewhere, such as Canada[22, 23].

Rural residents' experiences recorded in this study indicate access to maternity care becomes increasingly difficult as services are removed from their local hospitals. These difficulties are multi-faceted, being prompted by the increasing physical distance to maternity services (at regional centres) which leads to increased financial burdens, family-related issues and concerns about safety of care. These problems are rarely encountered by urban residents and are not adequately acknowledged and reimbursed by government subsidies. These issues highlight the inequity in access to maternity care experienced between rural and urban residents.

Further, decreasing access appeared to have negative influences on concerns about safety of care. Participants reported that removing local maternity services introduced new considerations about

accessing 'sanctioned' care. Considerations such as financial costs, personal distress, family disruption and leaving their families for extended periods of time, became important when parents were faced with obtaining care in regional centres. Participants reported that such considerations weighed heavily on decisions about relocation to a regional centre, and many delayed that until labour commenced. Similar considerations and decisions about accessing care have been noted amongst maternity patients in other areas of Australia that have experienced local service closures[21, 24]. High standards of clinical care are an important component of 'safety' in health services. However, assessing the safety of care by considering only the clinical or technical aspects can be limiting and is likely to overlook the detrimental effect that removing local services will have on rural residents' health help-seeking behaviours and the capacity of local services to handle future emergency situations.

POLICY RECOMMENDATIONS

The current policy environment espouses universal access to health care, but there is little practical policy support for the provision of maternity care in rural areas. Indeed, existing policies work against rural maternity care. Specific policies are required to support rural maternity care services, with particular attention paid to how policies may affect rural residents in seeking care. For example, the 'rural-proofing' concept in the UK encourages consideration of potential policy outcomes which may adversely affect rural services and communities[25]. Findings from this study also support continuing calls to improve financial assistance for individuals who must travel to obtain health care. This would immediately reduce some of the inequity experienced by rural families required to access maternity care outside their hometown. Increasing assistance to adequately cover costs of a support person to accompany a pregnant woman may also address some of the social and emotional concerns that reportedly prevent women from relocating to a regional centre in a normatively-determined safe and timely fashion.

Recommendations arising from this study are likely to be relevant beyond north Queensland. Although there is heterogeneity amongst rural Australian towns, most share common characteristics such

as long distances from comprehensive health care and health workforce shortages which were influential factors in this study. Recent Commonwealth Government attention[26-28], together with current research evidence provide an opportunity to make positive policy changes to improve rural Australians' access to maternity services. It is vital that this window of opportunity to create lasting reform and to realise positive change is not missed.

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