Health policy: outcomes for rural residents' access to maternity care

Rebecca Evans[1], **Craig Veitch**[2], **Richard Hays**[3], **Michele Clark**[4], **Sarah Larkins**[1]
[1]James Cook University, School of Medicine and Dentistry, [2]University of Sydney, [3]Keele University, UK, [4]Queensland University of Technology

Introduction

Regular health care during pregnancy, birthing and the postnatal period is recommended for improving maternal and neonatal outcomes and accessing such care has become a common expectation for Australian families. Studies have highlighted the relative safety of birthing in rural hospitals even though these units are typically associated with low volumes of deliveries[1-3]. Yet, in Queensland, the location and number of public maternity units shows a clear trend towards centralisation of services. During 1995-2005, 43% of Queensland public maternity units closed, with the remaining units predominantly located in coastal and more populated locations[4]. The closure of rural maternity units is not restricted to Queensland: the National Rural Health Alliance estimated 130 rural maternity units had closed across Australia throughout the decade 1996-2006[5]. Growing numbers of closed rural maternity units raises considerable questions regarding the care accessed by rural residents. This paper presents findings from research conducted in north Queensland which examined the impact of health policy on an issue that is of central importance to rural communities—access to birthing services.

A multi-dimensional understanding of access to maternity services was adopted in this study, a view which goes beyond measuring access only in terms of geographic distance. Gulliford et al.[6] have provided a constructive discussion of the multifaceted nature of access, particularly the differentiation between 'having access' and 'gaining access' to health care. Having access implies that a person has the opportunity to use a health service if they need or want it. This type of access is often measured in terms of doctors or hospital beds per capita and is dependent on the provision, and geographical allocation of resources, as well as the actual configuration of the network of health services. The authors draw attention to Mooney's proposition that equal costs in using a service (eg costs of care, costs of travel, lost work) indicates equal access to services[7]. On the other hand, gaining access to health care can be complicated by a variety of barriers including those of a personal nature (eg patients recognising their need to access health care); financial (that is, costs to be borne by the potential patient) or organisational (eg waiting lists).

The role of health policy in rural maternity care

Governments play a central role in the provision and organisation of health care services in Australia and health policy can be considered the tool used to influence health and health care services. Health policy has previously been described as the actions which affect institutions, organisations, services, and funding arrangements that form the health system[8]. However, a lack of government action, or non-decisions, should also be examined as policy decisions of government[9].

The objective of the present paper is to consider the interface between health policy and outcomes for rural north Queensland residents by seeking a greater understanding of (a) what influence government has had on maternity care services in rural north Queensland; and (b) how the policy discourse correlates with the lived experiences of rural residents in accessing maternity care. This approach implicitly acknowledges the need to consider policy discourse alongside the lived experiences of citizens who are most affected

by the policies[10]. Findings from this research should inform future health policies and also produce recommendations for service provision at the local level.

Method

The first phase of the project involved reviewing relevant government policies to identify the predominant discourse around rural maternity care. In the second phase, a case study methodology was employed to gain insight to the lived experiences of rural residents who seek access to maternity care or are involved in the provision of these services. Four north Queensland towns were chosen as study sites, each satisfying inclusion criteria of (i) being classified as a rural location[1]; (ii) located within the former Northern Area Health Service boundaries specified by Queensland Health at the time; and (iii) presently, or otherwise recently ceased, providing maternity (including birthing) care at the local hospital. Data for the case studies comprised observational data, documentary evidence and interviews with key stakeholders including hospital managers, clinicians and consumers of maternity care.

Parents were recruited for focus groups via local playgroups (most often at the suggestion of local health professionals) and the aim was to conduct at least one focus group in each town. Semi-structured question guides were developed for use in the focus groups and included questions on the present state of local maternity services, changes to the service, local versus removed birthing experiences, community engagement, expectations and quality of care. Focus groups were facilitated by the primary researcher and a member-checking technique was employed during focus groups to check the researcher's interpretation of participant responses. The focus groups were audio-recorded and subsequent transcriptions qualitatively analysed by the primary researcher using a grounded, iterative thematic technique [12, 13]. Focus group data were supplemented by interviews conducted with rural maternity care clinicians (nurses, midwives, hospital medical staff and rural general practitioners). Ethics approval for this study was obtained from the James Cook University Human Research Ethics Committee (H2264, H2453) and all participants completed informed consent forms.

Results

Prior to completing the case studies, a review of relevant government policies was undertaken and revealed a number of important themes. Firstly, there was a distinct lack of policies directly addressing the provision of maternity care specifically in the rural setting. Secondly, overarching principles of equity and universalism are prevalent in some of the most significant health policies implemented by the Commonwealth Government—an example being Medicare (which underpins the national health system) and the contractual obligations of the states through the Australian Health Care Agreements (AHCAs) which states that the Queensland Government should have arrangements in place "to ensure equitable access to such services for all eligible persons, regardless of their geographic location".[14] Rural health strategies[15-17] and policy frameworks[18] also contain strong themes of access equity. Lastly, several Queensland Health policy documents[19-21] and actions revealed three, interrelated, themes of particular relevance to rural residents' access to maternity services: centralisation of maternity care (particularly birthing); a concern to provide safe health care; and achieving cost-effectiveness in the health system.

[1] 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 11. Australian Institute of Health and Welfare. Rural, regional and remote health: A guide to remoteness classifications. AIHW cat. no. PHE 53. Canberra: AIHW; 2004.

Case study findings

Brief demographics for each town are presented in Table 1 and provide some descriptive background for the case study sites. Although hospitals at each of the case study sites worked within the same policy framework, there was a variety of outcomes at the four maternity units. One town had their birthing service cease just before data collection commenced. In contrast, a second town had a relatively strong roster of procedural medical practitioners and was able to maintain a traditional model of doctor-led maternity care. A third town had a doctor-led service though service provision was inconsistent, reflecting the availability of local procedural doctors. A fourth town was in the midst of trialling a midwife-led model of care. Each of the units had experienced downgrading of their maternity services to varying degrees with closure of the unit at one extreme and the removal of antenatal services (e.g. ultrasound services) at the lesser end.

Table 1 Characteristics of case study towns

	Town A	Town B	Town C	Town D
Predominant local industries	Agriculture	Mining	Agriculture	Agriculture
Population	11,625	8,469	12,244	19,460
Average birth rate 1996-2004	139	132	167	247
Local hospital size	60 beds (+8 for dialysis)	25 beds	28-30 beds	56 beds
Proximity to regional hospital	110km	135km	110km	70km

The number and various types of participants are listed in Table 2. Thirty-three parents were interviewed over five focus groups. All but one of these parents was female. Focus groups revealed a number of concerns regarding residents' access to maternity care. Firstly, rural residents wanted access to a local birthing service which is safe and operated with some consistency. Preference for local birthing appeared to be motivated by reasons of avoiding family inconvenience (minimising interruptions for spouse at work and care of children), removal from social support network and financial costs.

Table 2 Categories and numbers of participants

Interviewee category	Number of interviewees
Parents	33
Midwives	14
Directors of nursing	3
Nurse unit managers	3
Medical superintendents	3
Local general practitioners	4
GP obstetricians	6
GP anaesthetists	2
Senior medical officers at rural hospitals	5

Secondly, although maternity services may be free at the point of care (at hospitals and for public patients), the additional costs of travel, lost income, accommodation and living expenses have increased the financial barriers to accessing maternity services for many of the parents who participated in this study. At all sites, the downgrading or closure of the local maternity unit necessitated a minimum of one to two antenatal visits to the regional hospital, particularly for sonography services. Further, women planning non-local births are expected to relocate and be accommodated closer to the regional hospital two to four

weeks prior to their expected date of delivery. There are significant costs associated with such a lengthy relocation: the costs of travelling to the regional centre, being accommodated and fed while there and the lost family income which may result if the pregnant woman's partner accompanies her to the regional centre. Residents at each of the sites were eligible to obtain subsidies through the Patient Travel Subsidy Scheme (PTSS) which is operated by Queensland Health and provides financial assistance for people required to travel more than 50km to access approved health care services. However, focus group participants indicated that the subsidies are not nearly sufficient and perhaps not adequately advertised as some participants had not heard of the program.

> It's a contribution, it definitely doesn't cover the cost.
>
> They obviously don't make it very well known because we'd never heard anything about it.—Parents group A

Thirdly, there are social barriers associated with accessing non-local maternity care. Focus group participants noted how difficult it was to leave their families towards the end of their pregnancy, particularly if children were in school, or required child care, and if partners had to negotiate time off work.

> You've got children here to go to school, you've got children that are at home that need to be looked after, your husband's got to go to work. Who's going to pay for your accommodation? Even if you've got family, you've still got everything else to worry about.—Parents group B

For some, the additional costs of relocating the whole family for a period of time before and after birth precluded such options. Many women described the anxiety associated with having to leave their social support networks during such a significant time in their lives.

> My doctor told me to come 6 weeks before I was due because [child's name] was born 5 weeks early and I was organising [to go] and I would [say] 'I'll go next week'; 'I'll go next week' 'I'll go next week' and I eventually went [to the regional hospital] on the day that I went into labour. I just couldn't stomach going away from home. I just couldn't imagine . . . . I was going to stay with relatives and you're not comfortable in somebody else's house. . . . and you're in a really awkward state—Parents group C

Thus, social barriers associated with organising the family in preparation for relocation and the anxiety of being removed from family and friends appeared significant barriers to accessing maternity care services.

Fourth, safety became a major concern when the local birthing unit closed or had been downgraded (thus able to supply care to a smaller proportion of local pregnant women). The financial costs and social barriers to care mentioned above seemed to encourage riskier behaviour amongst the rural population; often causing women to delay their relocation to the regional centre until they were in the first stages of labour rather than some weeks prior. Regardless of whether a woman had chosen to delay relocation or had commenced labour unexpectedly early, health professionals and parents reported several dangers associated with travelling by road at this time including: (i) birthing en route to the referral hospital; (ii) if labour progresses rapidly, potentially having to deliver at the local hospital which may not be adequately equipped to manage births at that risk level; and (iii) the normal dangers of travelling by road from rural destinations where there is often only one highway connecting the rural and regional towns which can be closed in seasonal wet weather and treacherous at night (for example, increased risk of hitting wildlife). Parents at focus groups also reflected on the difficulty that women from lower socioeconomic backgrounds would have in obtaining reliable transport and the money required for attending antenatal appointments and lengthy relocations out of town. Participants largely concluded that foregoing antenatal care was a likely outcome in these cases. Furthermore, it was not uncommon for health professionals, particularly midwives, to relate stories of women avoiding local antenatal appointments and presenting at the hospital in advanced labour in order to avoid having to relocate to the regional centre:

. . . some of them just decide that they don't want to go [to the referral hospital] and so they go into hiding or they come in [to the local hospital] when they know it's too late to be transferred . . .—midwife

Discussion

So, what can be concluded about the influence of government policies on rural residents' access to maternity care? At the outset, it is important to note that governments' ability to directly affect citizens' experiences was severely constrained due to the lack of policies specifically relating to rural maternity care. Thus, government influence was largely observed via centrally-developed policies which did not necessarily take into account the differences inherent in rural settings and were generally did not support the sustainability of rural maternity units.

The correlation between policy discourse and the lived experiences of rural residents was mixed. Equity of access principles which prevail in Medicare and appear so often in the strategic objectives of macro-level health policies are not being achieved through present policy approaches. Rural residents' experiences recorded in this study indicate that access to maternity care becomes increasingly difficult as more services are removed from their local hospitals. Much of this difficulty can be related to the greater financial burden placed on rural residents; a burden which is not adequately reimbursed via existing PTSS rates. Maternity care may still be free at the point of service in public hospitals (as prescribed by Medicare and the AHCAs), yet gaining access to these services is associated with considerable financial costs which are rarely experienced by urban residents (being closer to services). According to Mooney's proposal that equal costs faced is equivalent to equal access, the present situation depicts inequitable access to care for rural residents.[7]

Parents believed that, rather than providing safe health care (as stated prominently in Queensland Health objectives) the loss of local maternity services was actually posing more risks for rural residents. Indeed, the perceived risks of delivery in a rural hospital (system or organisation risks) were being replaced with risks associated with travel and distance to care (personal risks); conceivably exposing rural residents to greater risk of adverse obstetric outcomes. Having no choice but to obtain care in regional centres introduced new barriers to care, including greater financial costs, family disruption and personal distress. Seeking to avoid or overcome these barriers, rural residents in this study admitted to engaging in riskier behaviour, for example, non-attendance at antenatal appointments that are not local or choosing to travel to the regional hospital in labour rather than complying with recommendations to relocate some weeks prior to expected due date. Such risk-taking behaviour following the closure of local birthing services has been noted amongst rural maternity patients in other regions of Australia [22, 23]. In addition, closure and downgrading of rural maternity services is likely to lead to local deskilling with potentially disastrous consequences for local obstetric emergencies where timely access to care is critical. A narrow assessment of 'safe' care is unlikely to take into account the detrimental effect on safety that remains in the rural community after the services are removed.

Further, it has been suggested that rural maternity unit closures are associated with cost savings[5]. Queensland Health policy documents clearly state the pursuit of cost-effectiveness in the state health system and hence, rural unit closures may provide intrinsic incentive to centralise health care. Nonetheless, centralisation of maternity services is placing greater financial burdens on rural families who are not adequately reimbursed by existing mechanisms, if at all. Any savings made by government are not being used to improve equity of access for rural residents and are not being used to offset the increased costs for individuals requiring maternity care.

Limitations

The purposeful sampling strategy successfully identified parents who recently had cause to access maternity care, but it is possible that participants from lower socioeconomic groups of each town may not have been adequately represented. Future research should specifically seek the experiences of families from lower socioeconomic groups, as findings from this study suggest that issues around accessing care would be exacerbated for those who endure greater financial hardship. In addition, this study did not assess whether participants identified as being Aboriginal or Torres Strait Islanders. It was unlikely that the sample contained sufficient participants to reflect the increased proportion of Indigenous Australians living in these rural towns. Further study should be undertaken to explore the lived experiences of rural Indigenous Australians using culturally appropriate research methods and sampling to encourage greater participation.

Policy recommendations

In light of these research findings, a number of realistic policy recommendations can be made with the aim of improving rural residents' access to maternity care services.

- The state government should make clear their position on rural maternity services via a dedicated policy approach. Any promise of support for rural maternity units should be accompanied by the financial and legislative means that would see government support translate to real change for rural communities.
- Requiring new government policies to include a mandatory rural impact assessment. Compulsory appraisals of potential rural impact and, if required, countermeasures to avoid negative outcomes would facilitate the development of policies which are more effective, acceptable and responsive to rural communities. The rural-proofing concept developed in the United Kingdom provides a framework for implementing such a process.[24]
- Improving financial support for rural families who must travel for maternity care. In the short term, and while inequities remain in rural residents' access to maternity care, the government must act to improve financial support for these families. Presently, rural families bear a greater financial burden in accessing maternity care than would be expected of their metropolitan counterparts. Removing financial barriers is an essential component of any plan to improve the equity of access to maternity care for rural Queenslanders. It is also important that appropriate advertising of this scheme occur to raise awareness amongst rural residents. Furthermore, financial assistance should be increased to allow for a support person to relocate with the pregnant woman; this would go some way to addressing the anxiety and social barriers that reportedly prevent women from relocating to the regional centre in a safe and timely fashion.

Conclusion

Overall, the lack of specific policy in rural maternity care has a constraining effect on government action in this area. While rural birthing services continue to close throughout rural areas of north Queensland, policy goals of equitable access to care, which underpin the Australian health system, are not being achieved. The centralisation of services which results from rural maternity unit closures has given rise to a number of financial, personal and social barriers to rural residents' access to care. Although unit closures may create financial savings for the health system, it is rural families who now bear a greater financial burden. Further,

the barriers to care appear to expose rural residents to more potential risks in obtaining maternity care, thus offsetting Queensland Health's organisational goal of providing safe health services.

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Presenter

Rebecca Evans is currently a PhD student at James Cook University. Her study explores the relationship between health policy discourse and the provision of maternity care services in rural areas of north Queensland. Her research interests include rural health service provision, health policy and equity.