PLACE OF BIRTH IN EUROPE

Introduction

Providing pregnant women with a choice of where to give birth is a policy goal in some European countries and also a high priority for some user associations (1). In 2010, few births occurred in small maternity units (fewer than 500 births), but this varied considerably by country. In ten countries from 10 to 20% of births took place in units of this size, while in Denmark, Sweden, England, Slovenia, Ireland, Latvia and Scotland 25% to 33% took place in units with more than 5000 births (Figure 1). The percentage of births occurring in maternity units with 3000 or more births per year has increased with the exception of Finland and Spain (2).

Many countries reported that less than 1% of births took place at home. In the Netherlands, where home births have been a usual option for women with uncomplicated pregnancies, 16.3% of all births occurred at home. This is a reduction from 2004, when this proportion exceeded 30%. Women in the Netherlands now also have the option of giving birth in a birth centre (a homelike setting) with or without care of the primary midwife (2).

Influencing factors

Macro, meso and micro factors can influence the options that women have about where and how to give birth, such as universal health coverage, influence of private obstetrics and the availability of midwives. In the last 5 years, emphasis has increased on how women's access to quality midwifery services has become a part of the global effort in achieving the right of every woman to the best possible health care during pregnancy and childbirth (3). National policies addressing maternity services have often ignored the centrality of the midwifery workforce and how it contributes to quality of care (4). Large variations are evident in the role, scope and funding of midwives, particularly in Europe. Even in countries with public health systems, the role and scope of midwives vary far more than that of other health professionals in the health care landscape (5).

The social, political and cultural organization of birth varies greatly even between high-income countries with similar levels of medical technology. Maternity policy is shaped by political systems, state organizations, the organization and regulation of professions and attitudes towards evidence based policy and risk in healthcare. Consumer organizations have played an important role in the debate about changing maternity care practices, resulting in media and government interest (6).

National policies and guidelines can support choice in place of birth. For example, since 1993 English maternity policy has supported choice of place of birth, recently reinforced in the 2014 National Institute for Health and Care Excellence clinical guidelines for intrapartum care. The guideline draws upon high quality evidence to support the choice of both multiparous and nulliparous healthy women in the choice of any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit). It outlines that for low risk nulliparous and multiparous women, planning to give birth in a midwifery led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. It advises that for low risk nulliparous women planning to give birth at home there is a small increase in the risk of an adverse outcome for the baby, however for low risk multiparous women the outcome for the baby is no different compared with an obstetric unit (7).

Provision

Despite national policies and guidelines to promote user choice in maternity services in many European countries, current trends in maternity unit closures create a context in which user choice may be reduced rather than expanded. Maintaining an adequate supply of maternity services, equity in choice as well as high standards of quality of care in remote rural areas is also a concern. The debate on the consequences of maternity unit closures has focused primarily on the spatial accessibility of services and less attention has been paid to their potential impact on pregnant women's choice of maternity unit. Proximity has been found to be particularly important. In this regard, use of an indicator measuring the proportion of women for whom the distance between the first and second maternity unit is greater than 30 km can provide a simple measure of choice to complement indicators of geographic accessibility in evaluations of the impact of maternity unit closures (8).

There is an ongoing debate about the association between the size of maternity units and quality of care, although it can be misleading when it ignores the types of care offered. In contexts where small units provide midwife-led care for women at low risk of obstetric complications within an organization that has facilities for transfer to units providing the full range of obstetric care if complications arise, results appear positive; that is, there is a growing body of evidence that midwife-led units and models of care provide similar outcomes for babies combined with lower levels of obstetric intervention and morbidity for their mothers, compared with units offering obstetrician-led care (9, 10). However, these units depend on a well organized referral system as transfers during delivery for unexpected complications are common.

Choice and cultural beliefs

Numerous factors can contribute to an individual woman's choice of place to give birth. Adequacy, abundance and proximity of supply all play a part in the decision making process. Women and families also have different perceptions of risk and value different aspects of quality. Culturally determined childbearing practices and beliefs distinguish some women from others. These include: choice of caregiver as midwife, obstetrician, family physician or traditional birth attendant; birth positions; caregiver gender; birth in hospital, birth unit or home; desirability of a partner/ companion during delivery;

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preference for intervention or non-intervention; mother–infant separation at birth or immediate skin-to-skin contact; nursery or rooming-in neonatal care; and breast or bottle feeding (11, 12).

Conclusion

The organization of maternity services and the choices available to women varies greatly throughout Europe. Comparisons of health outcomes, health practices and costs of care in these contexts would provide insights into the advantages and disadvantages of the diverse models of organization found in Europe.

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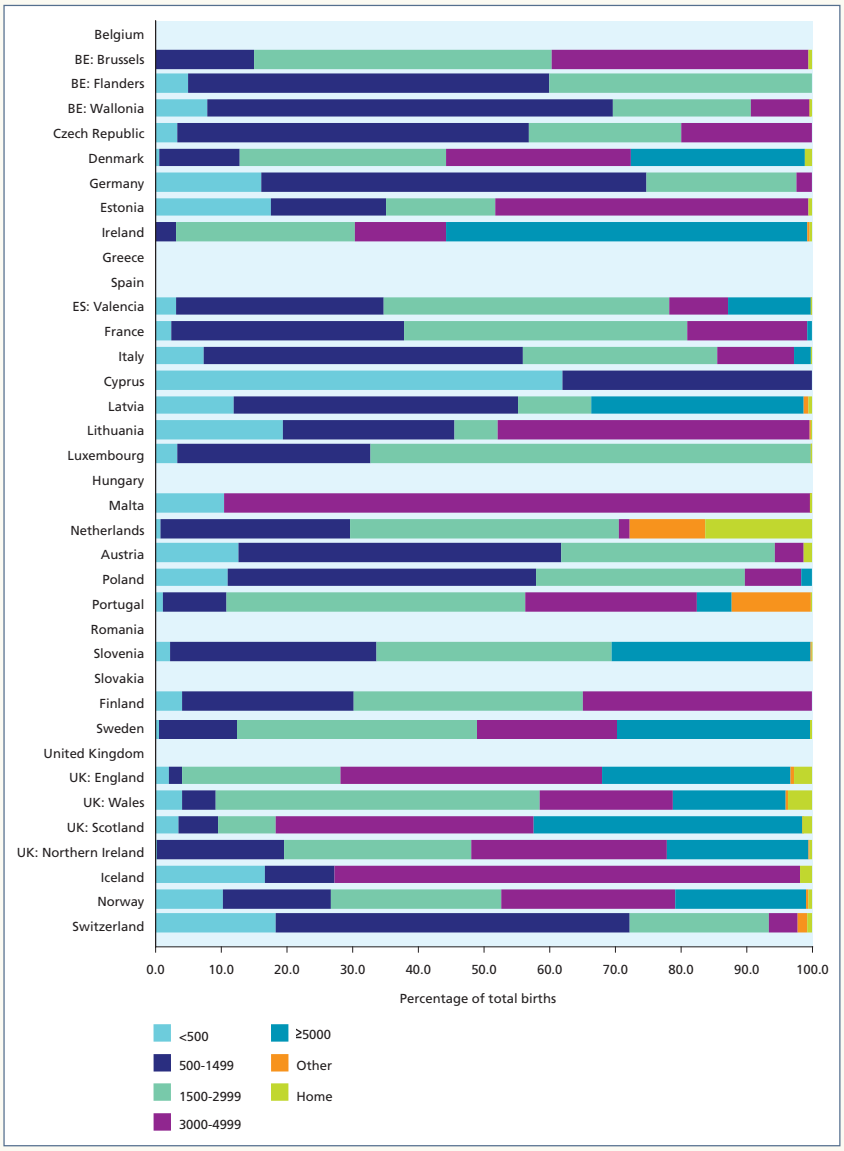
Figure 1. Distribution of births by maternity unit volume of deliveries in 2010. (Note: Twenty-nine countries or regions provided data for this indicator) (2).



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