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Publicly-funded home birth in Victoria, Australia: Exploring the views and experiences of midwives and doctors

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A R T I C L E I N F O

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A B S T R A C T

Objective: to explore midwives' and doctors' views and experiences of publicly-funded homebirthing models.
Design: cross-sectional survey implemented two years after the introduction of publicly-funded homebirthing models.
Setting: two public hospitals in Victoria, Australia.
Participants: midwives and doctors (obstetric medical staff).
Main outcome measures: midwives' and doctors' views regarding reasons women choose home birth; and views and experiences of a publicly-funded home birth program, including intrapartum transfers.
Findings: of the 44% (74/167) of midwives who responded to the survey, the majority (86%) supported the introduction of a publicly-funded home birth model, and most considered that there was consumer demand for the model (83%). Most thought the model was safe for women (77%) and infants (78%). These views were stronger amongst midwives who had experience working in the program (compared with those who had not). Of the 25% (12/48) of doctors who responded, views were mixed; just under half-supported the introduction of a publicly-funded home birth model, and one was unsure. Doctors also had mixed views about the safety of the model. One third agreed it was safe for women, one third were neutral and one third disagreed. Half did not believe the home birth model was safe for infants. The majority of midwives (93%) and doctors (75%) believed that intrapartum transfers from home to hospital were easier when the homebirthing midwife was a member of the hospital staff (as is the case with these models).
Key conclusions and implications for practice: responding midwives were supportive of the introduction of publicly-funded home birth, whereas doctors had divergent views and some were concerned about safety. To ensure the success of such programs it is critical that all key stakeholders are engaged at the development and implementation stages as well as in the ongoing governance.
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Introduction

Although the majority of Australian women give birth in hospital, a small proportion (0.4%) choose to give birth at home (Australian Institute of Health and Welfare, 2014). Like many developed countries, home birth is a contentious issue in Australia, with debate surrounding its safety when compared with hospital birth (Bryant, 2009). Until recently, women in Australia wanting to choose a home birth could only access this privately, with most having care provided by midwives in private practice (Catling-Paull et al., 2012). In response to consumer demand (Bryant, 2009; Dahlen et al., 2011), various publicly-funded home birth services have been established in the majority of Australian states and territories (Catling-Paull et al., 2012). The publicly-funded programs are usually available to women at low medical or obstetric risk (with strict inclusion criteria), are based within the public hospital system and are usually embedded within a midwifery group practice with obstetric consultation and referral as needed (Catling-Paull et al., 2012).

Differences in professional attitudes towards home birth have often been along disciplinary lines, with midwives more likely to be supportive of planned home birth, and medical staff more likely to view home birth as unsafe (Vedam et al., 2012; Vedam et al., 2014). A survey of nurse-midwives in the United States concluded that educational and clinical exposure influenced attitudes towards planned home birth, as did logistical, inter-professional and environmental factors (Vedam et al., 2009; Vedam et al., 2010). The Canadian Birthplace Study also identified differences in experiences of, and attitudes towards planned home birth between registered midwives and medical professionals (family doctors and obstetricians) (Vedam et al., 2014). Registered midwives who had greater exposure to home birth were less likely to view home birth as unsafe. All groups reported uncomfortable inter-professional relationships around planned home birth. Family doctors and obstetricians reported discomfort in discussing planned home birth with women.

An earlier United Kingdom (UK) study of full-time community midwives concluded that quality, rather than extent of experience was most influential in shaping attitudes to planned home birth (Floyd, 1995). Negative attitudes resulted from lack of specific skills (such as intravenous cannulation, perineal suturing and resuscitation), inadequate support, doctors' attitudes and confusion about emergency cover. In 2009, two publicly-funded home birth programs (called 'the home birth program' hereafter) were introduced in Melbourne, Australia as part of a Victorian Government-funded pilot. Casey Hospital (part of Monash Health) is located in the south eastern suburbs and has approximately 1300 births per year (Southern Health, 2011). Sunshine Hospital (part of Western Health), located in the western suburbs of Melbourne is situated in one of the most culturally diverse municipalities in Australia and has over 3700 births per year (Western Health, 2010). The two sites were chosen as pilot sites by the Victorian Department of Health because they both already operated a caseload (primary midwife-led continuity of care) model, had midwifery staff interested in working in home birth, and had management support for the program (Department of Health, 2011). Both hospitals also had well developed clinical governance structures, policies and procedures to operate their home birth programs (Department of Health, 2011). As part of the pilot, the Victorian Department of Health commissioned an independent external evaluation, comprising six components. These were consultation with key stakeholders, a review of relevant documentation, a survey of women who enrolled in the homebirthing pilot program, a survey of midwives working at each site (including midwives caring for women who planned a home birth and those caring for women who planned to birth in hospital ('standard care')), a survey of obstetric medical staff working at each site/hospital, a review of clinical outcome data, and an economic evaluation of the program (Department of Health, 2011).

This paper reports on two components of the evaluation, and aims to describe and compare midwives' and doctors' views regarding reasons women choose home birth and explore their views and experiences of a newly established publicly-funded home birth program. To our knowledge the views of midwives and obstetric medical staff in the context of publicly-funded home birth programs have not been previously studied in Australia.

Methods

This study used a cross-sectional survey design. All full and part-time midwives and obstetric medical staff (including residents, registrars and consultants; called doctors hereafter) at Casey and Sunshine Hospitals (whether or not they were directly involved in the home birth program) were invited to complete an online questionnaire.

The questionnaire was based on previous Victorian studies investigating midwives' views of maternity care models (Forster et al., 2009; Morrow et al., 2013; Newton et al., 2014) modified as necessary, and then piloted. Wherever possible, the survey questions and response options for doctors matched those for midwives. A project advisory committee comprising key stakeholders was convened by the Department of Health to provide input into the implementation and evaluation of the pilot. This group met with the research team a number of times during the evaluation, and provided feedback on the evaluation strategy, methods and content.

The questionnaire included mainly fixed choice questions exploring midwives' and doctors' views on why women choose planned home birth; views about, and experience of the home birth program operating at their hospital; perceived impact of the program; possible improvements to the program; and background/demographics. A small number of open-ended questions provided an opportunity for further comment.

Views and experiences of homebirthing and the publicly-funded homebirthing pilot program were explored under the following themes: perspectives on homebirthing, knowledge of the hospital's homebirthing program, criteria and guidelines, safety, support for the program and working in the program. Under each theme investigated, midwives and doctors were asked their views about a series of statements; they were invited to respond using a 5-point Likert scale with the following options: 1 = 'strongly disagree', 2 = 'disagree', 3 = 'neither disagree nor agree', 4 = 'agree', and 5 = 'strongly agree'.

An e-mail invitation to participate, which included an information statement, a description of the study and a web-link to the questionnaire, was distributed by a hospital manager at the respective sites. Hospital managers were unaware if staff chose to participate in the survey and had no access to responses. The researchers had no access to identifying information concerning participants and received responses with no identifiers. These features reinforced the evaluation's independence and ensured staff privacy and participant protection. Completion of the questionnaire was considered consent to participate.

The hospitals sent reminder emails to invitees at two fortnightly intervals. At the time of the second reminder, the number of responses was lower than expected so following ethical approval, hard copy questionnaires with prepaid addressed envelopes were also distributed by the project coordinator.

Once questionnaires were developed, they were loaded onto Survey-Monkey (SurveyMonkey.com, 2011) for completion by respondents. Hard copy survey data were added manually to the

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