Women and Birth 27 (2014) 281–291

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

Remote access and care: A comparison of Queensland women's maternity care experience according to area of residence

Julie Hennegan [a], Sue Kruske [a], Maggie Redshaw [a,b,*]

[a] Queensland Centre for Mothers & Babies, School of Psychology, The University of Queensland, Brisbane, Australia
[b] National Perinatal and Epidemiological Unit, University of Oxford, Oxford, United Kingdom

ARTICLE INFO

Article history:
Received 12 March 2014
Received in revised form 28 June 2014
Accepted 29 June 2014

Keywords:
Remote and rural
Maternity care
Pregnancy
Childbirth
Postnatal care

ABSTRACT

Background: This study fills a gap in the literature with a quantitative comparison of the maternity care experiences of women in different geographic locations in Queensland, Australia.
Method: Data from a large-scale survey were used to compare women's care experiences according to Australian Standard Geographical Classification (major city, inner regional, outer regional, remote and very remote).
Results: Compared to the other groups, women from remote or very remote areas were more likely to be younger, live in an area with poorer economic resources, identify as Aboriginal and/or Torres Strait Islander and give birth in a public facility. They were more likely to travel to another city, town or community for birth. In adjusted analyses women from remote areas were less likely to have interventions such as electronic fetal monitoring, but were more likely to give birth in an upright position and be able to move around during labour. Women from remote areas did not differ significantly from women from major cities in their satisfaction with interpersonal care. Antenatal and postpartum care was lacking for rural women. In adjusted analyses they were much less likely to have booked for maternity care by 18 weeks gestation, to be telephoned or visited by a care provider in the first 10 days after birth. Despite these differences, women from remote areas were more likely to be breastfeeding at 13 weeks and confident in caring for their baby at home.
Conclusions: Findings support qualitative assertions that remote and rural women are disadvantaged in their access to antenatal and postnatal care by the need to travel for birth, however, other factors such as age were more likely to be significant barriers to high quality interpersonal care. Improvements to maternity services are needed in order to address inequalities in maternity care particularly in the postnatal period.

1. Introduction

For many women, living in a rural or remote area has both benefits and challenges. Navigating maternity care is often much more difficult than for those in city or regional areas. Women face limited access to antenatal and postnatal care, the need to travel away from home and support networks to actually give birth, and the added emotional and financial costs associated with this travel.[1,2] The facilities available in rural areas do not provide the same level of clinical services as tertiary facilities in major cities, and specialists such as obstetricians or anaesthetists may be less available. In addition, private hospitals, and newer models of care such as midwifery group practices may also be less available or at further distances from these women.[3–5] Recent decline in the number of maternity services for rural and remote families in Australia and Canada due to closures in many states/provinces has been argued to further disadvantage this population, and received attention from advocacy groups.[6,7] In response, attention to the needs and experiences of women in rural and remote areas has increased. The vision of the Australian National Maternity Service Plan[8] is to achieve a service where "*All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live*." The plan prioritises improvements in care for Aboriginal and Torres Strait Islander (A&TSI) and women in rural and remote areas.

* Corresponding author at: Policy Research unit for Maternal Health and Care, National Perinatal Epidemiology Unit, University of Oxford, Old Road, Oxford OX3 7LF, United Kingdom. Tel.: +44 01865 289700; fax: +44 01865 289701.
E-mail address: maggie.redshaw@npeu.ox.ac.uk (M. Redshaw).

http://dx.doi.org/10.1016/j.wombi.2014.06.012
1871-5192/

To achieve the goals of the Maternity Service Plan and elicit effective change, it is essential to adequately understand the issues facing women in remote areas, and how their experiences differ from those in urban areas. Furthermore, any positive changes evoked by the implementation of policies or programmes (such as the Maternity Service Plan) cannot be effectively evaluated without a baseline understanding of the differences in experience. Whilst population-level data exists on clinical differences between urban and rural mothers, and qualitative studies have described the experiences of women in these areas, there is a significant gap in the availability of quantitative data assessing the pregnancy and maternity care experiences of this population. Little evidence exists comparing rural and remote women's experience with those with easier access to care, in Australia and other parts of the world, nor do current studies account for other demographic differences such as indigenous status, socioeconomic resources, or maternal age which may contribute to any differences observed.[9,10]

1.1. Rural and remote health

Australian national health surveys have often identified poorer outcomes for those living in rural and remote areas.[11] A review of urban–rural differences in health in high-income countries found considerable variation in differences across countries and health conditions.[10] In Australia, overall perinatal death rates have been found to significantly increase with rurality, with much higher rates identified in very remote areas compared to major cities.[11] However, much of this difference has been attributed to the much higher perinatal death rates for babies of Indigenous mothers.[11,12] Indeed review of rural–urban health disparity has emphasised the role that other demographic disadvantages such as minority group status, lower socio-economic status, and lower levels of education play in observed differences.[10] Emerging literature on remote and rural health has advocated for further analysis to investigate: if rurality represents a unique risk factor, the way rurality may interact with other non-spatial health determinants, and the role that accessibility may play in exacerbating other disadvantages.[1,9,10,13] A study seeking to address this question, compared babies born to Indigenous mothers in remote areas to those born in cities and found that even after adjustment for age, parity, smoking and diabetes or hypertension, babies born to mothers in remote areas were more likely to be of low birthweight and in poorer condition at birth.[14] The study suggested that, at least for this group, rurality represents a unique risk factor for health outcomes.

1.2. Rural and remote experience of care

Studies primarily conducted in Canada and Australia have documented the challenges that women from rural and remote areas face in accessing maternity care. Women encounter long travel times for check-ups, and must often relocate to a regional centre to give birth.[6,15–17] This brings with it added expenses of accommodation and travel costs as well as needing to arrange care for other children and time off work.[7,17] Themes from qualitative interviews and focus groups frequently reflect these issues with major themes being preferences for local care, concerns about accessing and travelling for care, and concerns about cost.[1,2,17] Themes of isolation are discussed in studies of remote women's health generally, as well as those specifically addressing maternity care.[17–19] Women can feel isolated or alone at home, in travelling long distances to reach antenatal or postnatal care appointments, and in relocating to another city or town to give birth. Relocating to another location for birth can occur weeks before doing so; resulting in many days spent in temporary accommodation alone.[3,18] Qualitative studies have also revealed themes around women's pride in their rural identity as well as some positive reports on the personal care provided by health care practitioners in smaller rural facilities.[19,20]

Few studies have investigated rural women's intrapartum care experiences. Bourgeault and colleagues[17] reported that rural and remote women described a poor quality of interpersonal care attributed to the busyness of care providers. Sutherns and Bourgeault[1] echoed this message, finding women in rural Canada reported poor quality of care including a lack of appropriate care, culturally sensitivity, or continuity of care. However, it should be noted that these focused studies did not compare care in a rural context with that experienced in urban settings. Interviews with Aboriginal women in northern Australia identified care provider beliefs, attitudes and practices were identified as barriers to high quality antenatal care.[21]

Limited quantitative data is available on women's experience of care. Parturient women travelling more than one hour to access services have been found to be more likely to experience moderate or severe stress than those with local access to care.[22] Wellbeing, specifically depression, has been compared between rural and urban women in one Australian study which found no difference in the prevalence of postnatal depression between urban and rural women, but found antenatal depression was more common in the urban group.[13] The study found demographic characteristics and past history of depression were both key in predicting postnatal depression with predictors slightly different for rural and urban mothers (with socio-economic status a significant predictor in rural, but not urban women). As discussed above there is increasing recognition of the role of other demographic factors in contributing to different clinical outcomes for rural women. Recent work on women's experiences of maternity care also suggest that these factors significantly impact upon experiences of care and quality of care ratings,[23–29] and thus these must be taken into account in any comparison of rural and urban women's experiences.

1.3. The present study

This study sought to address the lack of quantitative data on the way in which remoteness and rurality impacts upon women's clinical experience and experience of care; whilst considering demographic differences that may exist amongst the groups. The study utilises four groups based on the Australian Standard Geographic Classification[30] which measures remoteness in terms of the distance required to travel in order to access various levels of a range of services [see 31]; major city, inner regional, outer regional, remote and very remote. Those in major city areas face relatively unrestricted access to services, whilst, whereas those from remote and very remote areas have very little accessibility to services including any emergency medical services, and would need to travel for much more than an hour to access birthing facilities.[22,31] In 2011, 61.3% of Queensland birthing mothers lived in major city areas, 19.0% in inner regional, 15.5% in outer regional and 2.3% and 1.9% in remote and very remote areas respectively.[12] Each of these groups faces different environments and barriers to accessing antenatal, intrapartum and postpartum care. The study compares outcomes across the groups, but focusses on the experience of those from remote and very remote areas. The following research questions were addressed: (1) Are there demographic differences between the groups? (2) Were there reported differences in access and engagement with care at each stage of maternity care? and (3) Do women from different areas receive a different quality of care?