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Determinants of choice of delivery place: Testing rational choice theory and habitus theory

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ABSTRACT

Objective: The current study uses two antipodal social science theories, the rational choice theory and the habitus theory, and applies these to describe how women choose between intraclinical (i.e., hospital-run birth clinics) and extraclinical (i.e., midwife-led birth centres or home births) delivery places.

Design, setting, participants, measurements: Data were collected in a cross-sectional questionnaire-based survey among 189 women. A list of 22 determinants, conceptualized to capture the two theoretical concepts, were rated on a 7-point Likert scale with 1 = unimportant to 7 = very important. The analytic method was structural equation modelling. A model was built, in which the rational choice theory and the habitus theory as latent variables predicted the choice of delivery place.

Findings: With regards to the choice of delivery place, 89.3% of the women wanted an intraclinical and 10.7% an extraclinical delivery place at the time of their last child's birth. Significant differences between women with a choice of an intraclinical or extraclinical delivery place were found for 14 of the 22 determinants. In the structural equation model, rational choice theory determinants predicted a choice of intraclinical delivery and habitus theory determinants predicted a choice of extraclinical delivery.

Key conclusions: The two theories had diametrically opposed effects on the choice of delivery place. Women are more likely to decide on intraclinical delivery when arguments such as high medical standards, positive evaluations, or good advanced information are rated important. In contrast, women are more likely to decide on extraclinical delivery when factors such as family atmosphere during birth, friendliness of health care professionals, or consideration of the woman's interests are deemed important.

Implications for practice: A practical implication of our study is that intraclinical deliveries may be promoted by providing comprehensive information, data and facts on various delivery-related issues, while extraclinical deliveries may be fostered by healthcare professionals tailoring personal or social beliefs, attitudes and opinions. Our study advocates that legislation and policy- and decision-makers should support different delivery place options in order to accommodate the choices and preferences of different women. The study demonstrates the usefulness of theory for describing and explaining a complex decision-making process, here the choice of delivery place.

Introduction

Choosing a delivery place has been characterised as an important, complex and difficult decision-making process (Edwards, 2008). A number of previous studies, using both qualitative and quantitative designs, have explored determinants, factors, or predictors that influence the choice of delivery place, particularly the choice between in-hospital and out-of-hospital births. These studies identified that women's preferences for hospital or non-hospital settings are influenced by their values, beliefs and experiences (Coxon et al., 2017). More specifically, women choosing in-hospital births valued perceptions of safety, choice of medicalization and options for pain relief, or availability of medical staff (Hadjigeorgiou et al., 2012; Hollowell et al., 2016; Murray-Davis et al., 2014; Pitchforth et al., 2009). Women choosing out-of-hospital birth expressed a desire for continuity with the midwife, familiar environment, more self-determination, control over the birth process, and more involvement from partner, children and family (Bergmann et al., 2000; Borquez & Wiegers, 2006; Hildingsson et al., 2003; Murray-Davis et al., 2014).

However, these studies were not based on a theoretical framework to conceptualize the determinants of choice of delivery place, and were thus susceptible to ad hoc explanations. Although they generate important contextual information, they do not provide a systematic

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understanding of the choice of delivery place, nor do they provide ways to influence and change the choice process.

The current study uses two antipodal social science theories, the rational choice theory and the habitus theory, and applies these theories to explore how women choose an adequate delivery place. Rational choice theory was mainly worked out by Becker (1976), and its practical application is closely related to the Subjective Expected Utility theory (Savage, 1954). Rational choice theory is based on the economic behavioural model of "Homo Oeconomicus", which perceives people as rationally acting individuals that strive to maximise their own success. The theory posits that in the decision-making process possible alternatives are rationalized against each other by balancing benefits and costs, and the alternative with the highest utility, or usefulness, is chosen. Applied to choice of delivery place, the rational choice theory considers women as persons who strive to maximise the utility of their delivery decision, and their decision is determined by cost-benefit considerations, and is purely rational. The theory of planned behaviour, e.g. as a specific rational choice theory, has contributed to different fields in the public health arena (Kothe and Mullan, 2014; McDermott et al., 2015).

The term habitus has a long philosophical tradition (Sparrow and Hutchinson, 2013), and here we focus on the work of (Bourdieu 1984; Swartz, 1997), which contains various theorems, concepts, interrelations and theoretical frameworks to conceptualize social reality. This concept of habitus refers to a system of inner dispositions that guide people's perceptions, thoughts, and actions. It is shaped by one's past and present circumstances, affects one's present and future, and expresses itself in certain lifestyles and in ways of being. The habitus influences among other things an individual´s attitude toward choosing alternatives. According to the habitus theory, decisions are part of a social process, which is influenced by differing types of the social milieu and the social network. Thus decisions are based on personal values and wishes and on opinions from the social and professional environment. In the context of choice of delivery place, the habitus theory acknowledges that decisions are determined by personal, social, societal or cultural contexts.

The two theories were selected since they represent contradicting determinants for a decision-making process. The rational choice theory posits that decisions are made after careful consideration of various options. In contrast, the habitus theory suggests a rather intuitive, practical way to make decisions and emphasizes that decisions are influenced by both personal dispositions and social conditions. Essentially the rational choice theory and the habitus theory diametrically capture cognitive and emotional determinants, knowing and feeling, "head" and "heart", respectively. Moreover, as Bourdieu himself pointed out, one important motivation to develop the habitus concept was to oppose and extend the rational choice theory (Bourdieu and Wacquant, 2006). Thus, both theories provide a theoretical basis to conceptualise a decision-making process, here the choice of delivery place, but they do so from different, contradicting perspectives.

The research approach of the current study focuses on subjective conditions, i.e., individual rational or habitual motives of choosing a delivery place. Objective conditions, i.e., structures and legislation with respect to childbirth and midwifery, are held constant in our study, since it was conducted in one small town of Germany. A summary of such objective conditions in Germany may be in order. In Germany, women can choose between different options for births. The social security legislation (*Sozialgesetzbuch SGB V)* ensures free choice of delivery place and the right to midwifery for every woman. Midwives can accompany pregnant women and births on their own responsibility without having to consult gynaecologists. Women can choose between in-hospital births or midwife-led forms of out-of-hospital births including home births and births at birth centres. Costs for midwifery are generally covered by health insurances (belonging to the statutory health fund), but for out-of-hospital births an on-call service rate is required that is covered by some but not all health insurances.

Available data from Germany comparing in-hospital and out-of-hospital births seem to support the view that out-of-hospital midwifery care is safe for mother and child (Gesellschaft für Qualität in der außerklinischen Geburtshilfe, 2016). Furthermore, findings from a meta-analysis (Olsen, 1997) and from more recent studies in England (Brocklehurst et al., 2011), Iceland (Halfdansdottir et al., 2015) and New Zealand (Miller and Skinner, 2012) indicate that out-of-hospital births may be an acceptable alternative to in-hospital births for selected women without complications in pregnancy. However, all data are based on observational studies and may thus suffer from selection biases.

Despite the availability and safety of the various options for births, in Germany as in other developed countries of the Western world most children are born in a hospital-run birth clinic. The most recent figures available are for the year 2015, which show that a total of 740,362 children were born in Germany, and 730,800 or 98.7% of these in a hospital (Statistisches Bundesamt, 2015). Planned out-of-hospital births are reported at 1.3% of all births in Germany. In 2015, 11,039 singleton births were planned and started out-of-hospital, of these 37.4% were home births and 62.6% were births in midwife-led institutions such as independent birth centres (Gesellschaft für Qualität in der außerklinischen Geburtshilfe, 2016).

Methods

Sample

Data were collected in a cross-sectional questionnaire-based survey among 189 women in a city with 200,000 inhabitants in the federal state of Saxony-Anhalt in Germany. Women were eligible if they had given birth to their youngest child within the last two years, either in a hospital-run birth clinic (from now on referred to as intraclinical) or in a midwife-led birthing centre or at home (from now on referred to as extraclinical). Statistical data for Saxony-Anhalt reported only 109 extraclinical deliveries in 2013, a time period covered by this study (Gesellschaft für Qualität in der außerklinischen Geburtshilfe, 2014). Thus, intraclinical deliveries were expected to outnumber extraclinical deliveries in our sample.

Women were recruited as a convenience sample in cooperation with children's day care centres, birthing centres, self-employed midwives, and one hospital with an obstetrics clinic. Informed consent was assured, participation was voluntary, the survey was conducted completely anonymously, and all data protection regulations were met.

Assessment

Women completed a paper-and-pencil questionnaire that included socio-demographic characteristics, a single item regarding the choice of delivery place for their last child's birth (intraclinical or extraclinical), and determinants expected to influence the choice of delivery place. A list of 22 determinants that could play a role when deciding on a delivery place were rated on a 7-point Likert scale with 1 = unimportant to 7 = very important. These determinants were conceptualized to capture the two theoretical concepts; the rational choice theory and the habitus theory. For example, items based on the rational choice theory referred to the close proximity to the residence, good accessibility or infrastructure including availability of parking places, or high medical standards; items based on the habitus theory referred to recommendation of the delivery place by significant others, friendliness of nurses and midwives, or consideration of the women's interests. When developing the questionnaire, a seminal study using both the rational choice theory and the habitus theory to investigate determinants of choice for public or private schools was adapted (Suter, 2013). In addition, previous literature on various cognitive, emotional, motivational, and social aspects of choosing a delivery place was used as a guide to identify possible determinants (Bergmann et al., 2000; Hintze et al., 2002).