The Politics of Maternity in NHS Scotland

Summary from the Birth Project Group on the Politics of Maternity,
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The Birth Project Group is a cross-national undertaking involving midwives, academics and birth activists from Edinburgh Napier University; University of Edinburgh, the Pregnancy and Parents Centre, Edinburgh and Trinity College Dublin.

We now have first-rate evidence about what comprises best care for women in birth and the best start for new mothers, their babies, and their families.[1] Best outcomes for women at low risk come from caseloaded midwifery led care, either in a midwifery unit, alongside or freestanding, or home birth, all three integrated into community and tertiary NHS services as required.[2] We also have a good understanding as to why many women are not receiving optimum care and the lost chances to build individual maternal health for women and better broad health outcomes for our communities. Amongst other indicators,[3] a rising maternal mortality rate since 2007 across the UK is our most sensitive measure that all is far from well.[4]

The Health and Social Care Act, England has already led to the competitive tendering of some £65 millions of community midwifery service provision, much to the dismay of the London-based Royal College of Midwives. The RCM has raised serious concerns about the continued increase in the birth rate at the same time that maternity services are under severe pressure to cut costs[5], while an ageing midwifery workforce is subject to midwives burning out and dropping out. Outcomes for women are not as good as they should be when measured against international research.

In Scotland, training places have been radically reduced, cutting midwifery schools from six to three and cutting staff in those remaining three centres.

Of the approximately 58,000 births per year in Scotland, there is a normal birth rate of only 38% while the caesarean rate stands at 27%.[6]

It has proved very difficult to mainstream evidence-based cost effective care within the NHS in Scotland which would reduce the rates of interventions, increase safety and well-being for women and reduce overall costs. These are the figures below on cost effective care.

For women with low risks, the majority of women, the costs per birth are as follows:

£1066 home

£1435 free standing midwifery unit, like Montrose

£1461 alongside midwifery unit, like Edinburgh Royal

£1631 for consultant obstetric units[7]

Community based midwives are concerned about their reducing numbers and about top-down initiatives like the Early Years Framework which do take insufficient account of local capacities and how best to achieve the genuinely good outcomes for women from early pregnancy onward.

There is an excellent and proven model for this, the internationally recognised Albany Practice[8] which produced best outcomes for all women, especially those women experiencing multiple disadvantages. In a setting like East Glasgow for instance, where one in two children lives in poverty, an Albany model practice would immediately begin to raise the profile of health and wellbeing for young families in that community.

There is clear political expression in Scotland for not turning NHS Scotland into a commodity to be sold off piecemeal. This makes it easier to begin to ask what directions can NHS Scotland take to come closer to the expressed need and vision people now have to retaining health services as a core social good for all and to reducing health inequalities overall. Many of the administrative problems and aspects of the institutional culture of the NHS in Scotland and the historical issues of the costs of the three PFI hospitals[9] in Scotland are amenable to change in order to gain the NHS people need and want. Dr David Gillies, the Chair of the Royal College of General Practitioners Scotland makes the case for two broad changes in shifting resources in the most beneficial direction:

1. An extended network of primary and community –based care services
2. A 'communitarian approach' which entails a genuine inclusion of the community voice in the NHS and responsiveness to community need.

Below are ways to make these approaches and models like the Albany a reality in Scottish communities:

- community forums to give women and midwives the space to speak out about what they need
- bringing the research evidence to women and midwives to say this is what could happen
- rejecting the Fordist production line of care enforced on an overstretched and fractious NHS, dominated by concerns of about clinical indemnity and risk which actually create real risks for women, while midwives lose their confidence and skills
- helping communities to hear the stories of those women fortunate enough to who have had the care from midwives like those in Montrose and to hear how the Montrose community retained its midwifery unit and transformed it into a UK-wide award winning practice
- bringing pressure on the Scottish Executive and NHS Scotland to create more flexible midwifery services in the community and less centralised care

References

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9. Allyson Pollock estimates a PFI as costing between 12% and 14% of any given NHS budget for 30 years, See her *NHS PLC*, 2004:2

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