Antenatal care by a general practitioner or midwife was less expensive than obstetrician-led shared care

Ratcliffe J, Ryan M, Tucker J. **The costs of alternative types of routine antenatal care for low-risk women: shared care vs care by general practitioners and community midwives.** Journal of Health Services and Policy. 1996;1:135-40.

Objective

To compare the costs of traditional obstetrician-led shared care with care by a general practitioner (GP) or midwife for pregnant women at low risk for complications.

Design

Cost comparison based on clinical data from a randomised controlled trial.

Setting

51 general practices linked to 9 maternity hospitals in Scotland.

Patients

1765 pregnant women who were at low risk for complications at the outset of their pregnancy. Exclusion criteria were previous obstetric conditions, such as perinatal or neonatal loss, severe preeclampsia, previous caesarean section, or the previous baby having a birthweight < 2500 g or being delivered before 34 weeks' gestation; medical conditions, such as diabetes, hypertension, cardiac or renal disease, substance abuse, or weight problems; or current pregnancy conditions, such as multiple pregnancy, age < 16 or > 35 years, low haemoglobin concentration, or isoimmunisation. Cost data were available for 1667 women (94%).

Intervention

Women were allocated either to shared care in which an obstetrician supervised their routine antenatal care in conjunction with a GP or midwife ($n = 840$) or to care exclusively from a GP or midwife ($n = 827$).

Main cost and outcome measures

Health service costs included estimated costs of tests and investigations based on a cost analysis in a Glasgow, Scotland, maternity hospital, cost of routine visits (assumption of 15 min/visit), personnel costs, and costs of nonroutine care (day and inpatient stays). Non–health service costs pertained to costs incurred by the patient: travel to and from appointments, child care costs, loss of earnings, and costs to companions for aid in atte appointments.

Main results

GP or midwife care costs less shared care. The total mean co patient for investigations va compared with £91 (P = 0.05 staffing costs of routine care, compared with £131 (P = 0.01 for non–health service costs inc by patients and their compar £119 compared with £133 (P = 0 The groups did not diffe nonroutine care costs (£84 vs P = 0.46). The total mean societ was lower for GP or midwife compared with shared care (£4 £450, P = 0.03).

Conclusion

The costs of tests and investiga staffing, and costs to patients were for pregnant women who receive tine antenatal care from a genera titioner or midwife than from a stetrician-led shared care team.

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Commentary

The background to the study by Ratcliffe and colleagues is an official policy change toward a greater role for GPs and midwives in the care of pregnant women at low risk for complications. The likely benefits of this change are increased continuity of care, greater choice of caregiver, and more care that is locally available.

In Scotland, 3 different policy options were evaluated in randomised trials: a midwife-managed delivery unit compared with consultant-led care in labour (1); midwife-managed care compared with care shared among midwives, GPs, and hospital doctors (2); and obstetrician-led shared antenatal care compared with care by GPs and community midwives (3). This study provides a comparison of the costs of care to health services and to women and their families.

The strength of this study is the clarity with which the methods and assumptions are described. You do not need to be an economist to understand it. Community-based antenatal care by a GP or a midwife costs health services and pregnant women and their companions less, even if opportunity costs of staff time are zero. Although the savings per patient are not extensive, the high proportion of women to whom the findings are relevant (just over half of the antenatal population were defined as low risk) makes this model of care an efficient choice to offer to low-risk pregnant women (3), at least in Scotland where a functioning network of maternity providers exists across professional boundaries.

An unqualified recommendation is precluded because, although clinical outcomes were satisfactory and satisfaction with care by a GP or midwife was higher, th lacked the power to assess substantiv cal outcomes.

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