Social Obstetrics - Non-local Expectant Mothers Delivering Babies in Hong Kong

Dr. WC LEUNG

MBBS, FRCOG, FHKAM(O&G), Cert RCOG(Maternal and Fetal Med)
Consultant Obstetrician, Department of Obstetrics & Gynaecology, Kwong Wah Hospital, HKSAR

Dr. WC LEUNG

Introduction

When standard obstetrics practice is affected by a socio-economic situation, it can be described as ***social obstetrics.*** Ever since the Court of Appeal's decision in 2001 allowing Chong Fung-yuen (born while his parents were in HK on two-way permits) to stay in HK, an increasing number of non-local expectant mothers have travelled from the China Mainland to HK to deliver their babies for a special social reason - these children will then have the right to stay in HK (Figure 1). Some of them also come to evade the Mainland's one-child policy. In the past, these women were usually married to a Hong Kong resident husband, but now, more and more of these couples are both Mainland residents. These mothers have to pay much higher fees to use the public health service. In the past, the obstetric package was HK$20,000 for 3 days and 2 nights' of hospitalisation including delivery + $3,300 per extra day, which resulted in many non-booked cases. The last minute help-seeking behaviour of these mothers can result in adverse pregnancy outcomes. From 1st February 2007, a new system of antenatal care and delivery bookings for non-local expectant mothers commenced in Hospital Authority hospitals (http://www.ha.org.hk). They now have to pay $39,000 for an obstetric package covering the first antenatal visit, delivery and birth-related hospitalisation for 3 days and 2 nights. Any additional clinic visit costs $700 and any additional day in hospital costs $3,300. Those who come for deliveries but have not booked will be charged $48,000. The new system significantly reduces the number of non-booked cases but still defers the non-local expectant mothers from having adequate antenatal care, leading to adverse pregnancy outcomes or near miss scenarios. They would usually go back to the Mainland after the first antenatal visit in Hong Kong and then came back at term either to the antenatal clinic once or directly to the labour ward when in labour. In principle, there could be shared antenatal care between Hong Kong and the Mainland. But in reality, this form of shared care was often suboptimal because of the difference in clinical practice and culture between Hong Kong and the Mainland. Furthermore, those non-local expectant mothers who were evading the one-child policy would avoid antenatal care in the Mainland to hide their pregnancy.

I have chosen the following six common scenarios to illustrate this ***social obstetrics*** phenomenon.

1. Perinatal Mortality Due to Extreme Postmaturity

This used to happen before 1st February 2007 with the old obstetric package i.e. $20,000 for 3 days and 2 nights' of hospitalisation including delivery + $3,300 per extra day, which resulted in many non-booked cases. At that time, these non-local expectant mothers tended to come to the hospital through the A&E Department at the last minute, often just after midnight in order to maximise the $20,000 covered 3 days and 2 nights' period, only when they are in active labour, even when they were post-term. We had reported two cases of postmaturity-related perinatal mortality with delivery at 42 weeks 6 days and 44 weeks gestation respectively (HKMJ 2007;13:231-3). The standard obstetrics practice would be induction of labour at 41 weeks.

2. Untreated Gestational Diabetes

Gestational diabetes is one of the most common obstetric complications affecting 10 to 20% of Chinese pregnant population. The standard management includes universal screening, diagnosis by oral glucose tolerance test (OGTT), diet control, home blood glucose monitoring, Insulin treatment for poorly controlled cases, monitoring for foetal growth, liquor volume & foetal well-being, and an appropriate time of delivery. Untreated cases could result in perinatal morbidity and mortality. It was difficult for non-local expectant mothers to comply and follow the recommended management of gestational diabetes. They would usually go back to the Mainland after their first antenatal visit and would not come for antenatal check-ups until delivery. Some of them did have OGTT in the Mainland but more of them did not have satisfactory control of blood glucose levels. The situation was even worse for those women who were evading the one-child policy because they would not attend regular antenatal care in the Mainland. Thus it was not unusual to find an affected foetus when they came to Hong Kong at term for delivery. Intrauterine foetal death had occurred in some cases as well.

3. Time of Delivery for Pre-eclampsia - Either Too Early or Too Late

Pre-eclampsia is another common obstetric complication which can result in significant maternal and perinatal morbidity and mortality. The standard management includes early recognition by detecting high blood pressure and proteinuria during regular antenatal visits, close monitoring of maternal and foetal well being, the use of antihypertensives, and most importantly, the decision on the best time for delivery of the baby. It is not difficult to understand why non-local expectant mothers with pre-eclampsia cannot follow the above standard management. They could appear too late in our labour ward with eclampsia, acute renal failure, pulmonary oedema and severe intrauterine foetal growth retardation. On the other

hand, some of them might come to Hong Kong to request a Caesarean section once they had been diagnosed to have early pre-eclampsia in the Mainland, despite the fact that it would be possible to buy some time for foetal maturity with antihypertensives and close monitoring. If their unreasonable request was not entertained, discharge against medical advice (DAMA) was almost always the case. DAMA was also common in intensive care unit (ICU) when those women were just recovering from eclampsia and other complications.

4. Unexpected Major Placenta Praevia / Accreta

Placenta praevia / accreta is a major cause of massive antepartum and postpartum haemorrhage which can be life threatening. Successful management depends on early diagnosis, in-patient stay for major cases, elective Caesarean section at term with adequate preoperative preparation which includes the availability of adequate blood products, standby uterine arteries embolisation, surgical expertise for compression sutures and emergency hysterectomy, and most importantly, a team approach. Non-local expectant mothers with major placenta praevia usually turned up only when there was vaginal bleeding, sometimes massive, which precludes an adequate preoperative preparation before emergency Caesarean section. Even when the diagnosis of placenta praevia / accreta could be made earlier, they would refuse in-patient management because of financial concern.

5. Haemoglobin (Hb) Bart's Hydrops Foetalis - Back to the 70's

Thalassaemia is the most common single gene disorder in our locality. Universal screening using mean corpuscular volume (MCV≤80fl) for thalassaemia couples in pregnancy has been well established since 1980's. When both parents are having alpha-thalassaemia trait, there is a 1 in 4 chance that their offsprings will suffer from alpha-thalassaemia major or Hb Bart's. Foetuses with haemoglobin Bart's can be identified by ultrasound examination and chorionic villus sampling / amniocentesis. The affected pregnancies are usually terminated. As a result, it is rare nowadays for Hb Bart's foetuses to go into the third trimester of pregnancy and to develop hydropic changes, which were common before 1980's. Unfortunately, we began to see Hb Bart's hydrops foetalis coming back in non-local expectant mothers because of the breakdown in the continuity of antenatal care in pregnancy - an important component of the ***social obstetrics*** phenomenon.

6. Requesting Caesarean Section Because of Cord Round Neck

Cord round neck is a common finding in obstetrics - 10 to 20% of healthy babies at birth have umbilical cord round neck. Although cord round neck could result in intrauterine foetal death, this is rare and should be considered as an obstetric accident. It is usually not necessary to look for cord round neck during obstetric ultrasound examination which could create unnecessary maternal anxiety. Interestingly, cord round neck was a very common finding in the ultrasound reports from the Mainland. It was not uncommon to have non-local expectant mothers coming to our antenatal clinic requesting Caesarean section based on this finding. When we could not satisfy their request, complaints would arise despite any explanation on the nature of cord round neck and that it is not an indication for Caesarean section per se.

Conclusion

Non-local expectant mothers delivering babies in Hong Kong has become a classic ***social obstetrics*** phenomenon. There is nothing wrong with these mothers who would like to have their children born and to become citizens in Hong Kong. We could probably remember it was not long ago when Hong Kong mothers would like to have their children born and to become citizens in USA or Canada. The non-local expectant mothers are not coming to Hong Kong illegally either. Perhaps the gray area is whether those mothers who are evading the one-child policy by delivering their second baby in Hong Kong should be considered as violating the population policy in the Mainland. With positive thinking, non-local expectant mothers are income generating for both the public and private sectors of obstetrics. The near miss clinical scenarios arising from this ***social obstetrics*** phenomenon provide invaluable training opportunities for our trainees and ourselves. In return, we should try our best to minimise the adverse pregnancy outcome resulting from this ***social obstetrics*** phenomenon and to resolve the conflicts between local and non-local expectant mothers on the already limited resource allocation.

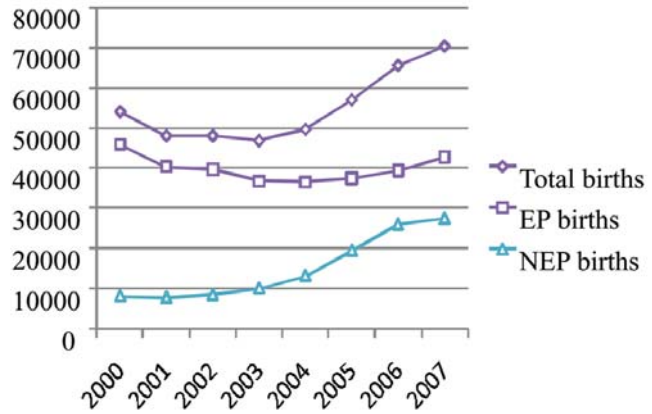

Figure 1. Number of Births in Hong Kong (NEP denotes non-eligible person, and EP eligible person)
(Source: Census and Statistics Department, HKSAR)

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