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• 中文關鍵字	高危險妊娠；產前檢查；盛行率；危險因子；較差妊娠結果；；；
• 英文關鍵字	high-risk pregnancy；prenatal care；prevalence；risk factor；adverse pregnancy outcomes；；；
• 中文摘要	高危險妊娠爲所有讓母體與胎兒的生命健康處於危險狀態，讓死亡或殘障的機率有明顯增加的妊娠，高危險妊娠的發生率約 19%，但其周產期死亡率卻是 70%，因此產前檢查可提供適當醫療照護、評估危險因子，以早期偵測高危險妊娠的母嬰，提供醫療介入措施，以提升母體與胎兒的健康狀況，降低其死亡率與併發症。根據行政院衛生署的統計資料(行政院衛生署，2006)，近十年來我國新生兒死亡率由千分之 3.3 下降至 2.7; 而近十年來孕產婦死亡率亦十萬分之 9.2 下降至 6.5。但我國孕產婦與新生兒死亡率仍高於部分經濟合作與發展組織(OECD)會員國，周產期與產前檢查的照護仍需要持續努力使其更趨完善。 因此，本研究爲孕婦產前檢查品質監測計畫，運用次級資料分析，評估並探討周產期緊急醫療網 19 項高危險妊娠項目與較差妊娠結果之盛行率、相關危險因子(包括社會人口學變項、個人生產史與疾病史等)與醫療院所區域影響因素等。 本研究擷取 94 年度所有懷孕的婦女後，分析其周產期至 94 或 95 年度，並回溯在承保抽樣歸人檔中所擷取之孕婦自 85 年以來的就醫史，並串聯出生登記通報資料，進行資料統計與分析。研究分析分爲兩部份進行： 第一部份：運用 94-95 年度健保資料(包括承保資料檔、門診處方及治療明細檔、門診處方醫令明細檔、住院醫療費用清單明細檔、住院醫療費用醫令清單明細檔、醫事機構基本資料檔等)，擷取 94 年度所有懷孕婦女資料，分析其周產期，串聯出生登記通報資料，進行 94 年度所有懷孕婦女 19 項高危險妊娠的盛行率與較差妊娠結果影響因素分析。 第二部份：運用 2007 年發行的承保抽樣歸人檔，回溯該檔所擷取之 94 年懷孕婦女過去十年的就醫史(各年度使用資料庫包括承保資料檔、門診處方及治療明細檔、門診處方醫令明細檔、住院醫療費用清單明細檔、住院醫療費用醫令清單明細檔)，並串聯出生登記通報資料，分析其周產期，進行 19 項高危險妊娠的各項流行病學危險因子分析探討。 研究發現，我國懷孕婦女在健保給付的十次產檢中，平均產檢次數近八次，第一次產檢週數約在妊娠十週時，應符合建議，但花東地區第一次產檢週數較晚，在重要產檢(即前五次)使用中，相較於完整使用五次者，使用 3-4 次者，其胎兒極低出生體重(OR=3.7, 95%CI=(3.1-4.3))、低出生體重(OR=1.2, 95%CI=(1.1-1.2))與早產(OR=1.1, 95%CI=(1.1-1.2))風險都顯著提高，而僅使用小

	於兩次者，其胎兒極低出生體重(OR=9.3, 95%CI=(7.2-11.9))、低出生體重(OR=2.0, 95%CI=(7.8-2.2))與早產(OR=1.7, 95%CI=(1.5-1.9))風險顯著更爲提高。在重要高危險妊娠盛行率方面，本研究發現妊娠合併慢性高血壓與子癇前症的盛行率爲千分之 9.8，妊娠合併糖尿病的盛行率爲千分之 27.9，妊娠合併心臟疾病的盛行率爲千分之 2.8，35 歲以上的高齡是多數高危險妊娠與較差妊娠結果的獨立且重要影響因子，孕前三年的個人疾病史與高危險生產史亦顯著與高危險妊娠相關，不同高危險妊娠類別的疾病影響因子有所不同，因此醫師進行妊娠風險評量與產前檢查項目規劃時，可以由孕前個人疾病史與高危險生產史進行各種高危險妊娠的評估與介入。 整體而言，我國產前檢查現況大致符合建議標準，但東部、南投與離島地區產檢涵蓋率稍偏低，第一次產檢的時間也較晚，針對這些地區應加強產檢就醫便利性，提高產檢使用並提早進行第一次的產檢等適當的衛教觀念;在高危險妊娠方面，可妥善利用社會人口學因子、孕前個人疾病史與生產史作爲產前檢查評估規劃的參考，以期提高產前檢查品質並降低高危險妊娠之風險。最後，未來研究可進一步研討降低後五次(於妊娠 34-40 週進行)產檢次數的可能性，以實證研究完整考量孕婦產前檢查就醫動機、行爲、健康狀況與行爲及其妊娠併發症與妊娠結果之效應，評估酌量拉長妊娠最後六週產檢時程之影響與可行性，以達到醫療資源有效利用的經濟效益。
• 英文摘要	High risk pregnancies significantly increase the risks of death and disability and endanger both mothers and fetuses. The incidence of the high risk pregnancy is estimated to be 19%, while the death rate during gestation is up to 70%. It has been demonstrated that prenatal care may evaluate essential risk factors and help offer appropriate medical care for pregnant women. With the detection of high risk mothers and fetuses in early stage, proper medical intervention can be proposed to promote maternal and fetal health status and to decrease the rates of complications and death. Based upon reports from the Department of Health, the Executive Yuan (the Department of Health, the Executive Yuan, 2006), the neonatal mortality rates in Taiwan decreased from 3.3 per thousand to 2.7 per thousand in the past decade. In addition, the death rates of the pregnant women decreased from 9.2 per one hundred thousand to 7.3 per one hundred thousand in the past decade. However, the mortality rates of the neonates and the pregnant women were still higher than some OECD (Organisation for Economic Co-operation and Development) countries. Constant efforts should be made to promote the comprehensiveness of the prenatal care in Taiwan. Thus, this study aims to monitor the quality of the prenatal care in Taiwan. With the use of the secondary data analyses, prevalences, related risks factors, and the hospital effects will be evaluated for the 19 selected diseases among the high risk pregnancy items. This study will select all pregnancy women in 2005 and follow their gestational weeks till 2005 or 2006. In addition, pregnant women in the Longitudinal Health Insurance Database 2005 will be selected, with their medical claims records obtained since 1996. Data from the birth certificate registry will also be utilized. The analyses were organized in the following two parts: Part I: Medial claims data (including Registry for beneficiaries (ID), Ambulatory care expenditures by visits (CD), Details of ambulatory care orders (OO), Inpatient expenditures by admissions (DD), Details of inpatient orders (DO), and Registry for contracted medical facilities (HOSB)) for all pregnant women in 2005 will be utilized for analyses, together with the data from the birth certificate registry. Maternal gestation will be followed to investigate the prevalences and the hospital effects on the 19 selected diseases among the high risk pregnancy items. Part II: The Longitudinal Health Insurance Database 2005 will be used to retrieve medical claims records (including Registry for beneficiaries (ID), Ambulatory care expenditures by visits (CD), Details of ambulatory care orders (OO), Inpatient expenditures by admissions (DD), and Details of inpatient orders (DO)) for the past 10 years for women who were pregnant in 2005, together with the data from the birth certificate registry. The epidemiology and risk factors of the 19 selected diseases among the high risk pregnancy items will thus be investigated. We found that as recommended, the prenatal care coverage rate was

approximately 7.9, with the timing of the first visit at the 10th gestational week in Taiwan. In addition, compared with those who utilized all first five important prenatal visits, those who used 3-4 times experienced increased risks of having a newborn with very low birthweight (OR=3.7, 95%CI=(3.1-4.3)), low birthweight (OR=1.2, 95%CI=(1.1-1.2)), and preterm birth (OR=1.1, 95%CI=(1.1-1.2)). Women who used less than 2 times experienced even higher risks of having a newborn with very low birthweight (OR=9.3, 95%CI=(7.2-11.9)), low birthweight (OR=2.0, 95%CI=(7.8-2.2)), and preterm birth (OR=1.7, 95%CI=(1.5-1.9)). For the prevalences of high-risk pregnancies, the prevalence of pregnancy with chronic hypertension and preeclampsia was 9.8 per 1,000 women, that of pregnancy with gestational diabetes was 27.9 per 1,000 women, and that of pregnancy with heart disease was 2.8 per 1,000 women. Advanced age was a single independent risk factor for most high-risk pregnancies and adverse birth outcomes. Personal disease and birth histories three years prior to the index pregnancy were significantly associated with high-risk pregnancies, with different illnesses affecting on various high-risk pregnancy items. Obstetricians should evaluate risks of pregnancy and plan appropriate prenatal care items based upon personal disease and birth histories prior to the gestation. In sum, the prenatal care in Taiwan generally conforms with what has been recommended in literatures. However, eastern Taiwan and certain counties out of the Taiwan Island had lower prenatal care coverage rate and later timing of the first visit. Future programs should be designed and administered to facilitate access to medical care and to promote appropriate knowledge on prenatal care through health education. Sociodemographic factors and personal disease and birth histories prior to the index pregnancy can be utilized to evaluate, plan, and implement appropriate prenatal care frequencies and items. It is hoped that the hazards of high risk pregnancies in Taiwan could be effectively decreased and the health for both mothers and fetuses could be well promoted. Finally, future studies may investigate the possibilities of reducing prenatal care visits for ultimate healthcare utilization.