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Why is it so hard?

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Colm OBoyle explains how the HSE removes agency, making homebirth in Ireland so difficult

Homebirth midwives in Ireland feel under threat.[1] This is due to a combination of historical factors and recent changes in legislation with regard to professional indemnification. For those unfamiliar with Irish health and maternity services, a very brief historical overview is necessary to situate midwifery and homebirth and give some context. With that background then, the consequences of EU requirements for clinical indemnification will be considered.

Organisation of health care

Ireland became a free state in 1922 and a republic in 1948, just at the point when the NHS was being inaugurated in the United Kingdom (UK). However Ireland's health ser vices did not follow the UK, free at the point of use, model. The Health Service Executive (HSE) is the executive arm of the Irish health service and implements the policies developed by the Department of Health (DoH). The HSE charges for admission to accident and emergency departments and for hospital stays. General practitioners (GPs) are regarded by the HSE as private practitioners and, although the primary gatekeepers to all other health services, they also charge for visits. There is, therefore, no free national health service in Ireland.

There is a means tested medical card system that enables free access to GPs and public HSE services for the financially most vulnerable. Private medicine and private health insurance are and have long been integral to the Irish health service. There are some private hospitals in the State but most 'private' beds and services are located within public hospitals. Maev-Ann Wren[2] has written about how the private system can be characterised as parasitising upon the public health services.

How maternity care is organised

Maternity services similarly have been historically divided into public, private and semi-private care. Only recently (1991) have maternity ser vices became freely available to all women, which means many women still use private health insurance to pay for obstetric antenatal care and private postnatal beds in public maternity hospitals.

Most babies in Ireland (over 99%) are now born in consultant led obstetric hospitals, and so maternity services are largely funded under the HSE acute hospital services sector. Early transfer home (ETH) and DOMINO (Domiciliary in and out) schemes, are not yet widely available and where they are, are often developed as a means to ease pressure on busy hospital ser vices. There are only two small midwifery led

units (MLUs) in the North East of the country. The National Maternity Hospital's (NMH) Community Midwifery Scheme provides a DOMINO and homebirth service but only in a small area of south Dublin. Primary care generally, but maternity ser vices and community midwifery particularly, have been recognised as being sorely underdeveloped in Ireland.[3,4,5] With maternity services being so dominated by acute hospital provision there seems little scope for expansion of community midwifery except through the development of hospital outreach schemes. Unfortunately though, it is not easy to develop these schemes without diver ting resources away from the already stretched hospital sector.

The Maternity and Infant Care Scheme (MICS)6 which facilitates shared GP/hospital antenatal care is funded from the HSE Community (primary care) budget. Many women use this free and integrated GP service which includes a six-week postnatal check for mother and baby. There is, however, no national community midwifery service and so postnatal ser vices are otherwise provided by public health nurses who have considerable other nursing ser vice demands that take priority.

Homebirth provision?

Despite mid twentieth century health service policy recommendations for hospital birth, the public private mix within Irish health services provision allowed the payment of 'grants' to pay for homebirths. Fewer than 20 independent midwives, now known as Self-employed Community Midwives (SECMs) continued to provide homebirth ser vices, but some (no one knows how many) women were unable to access a homebirth. In 2003, several mothers took the HSE (then known as the Health Boards) to court demanding homebirth ser vices. The Supreme Court[7] ruled, however, that the HSE was not obliged to provide homebirth and, essentially, that they could deliver whatever maternity services they saw fit. The High Court in 2013,[8] reaffirmed that ruling stating that the HSE was not required to provide home VBAC not only on the basis of the 2003 ruling, but because the HSE could be obliged to accept liability for births it 'reasonably' considered a risk.

This summary of the historical context of midwifery, maternity and homebirth services in Ireland sets the scene for the next section which considers professional indemnification.

Controlling and restricting midwives' practice

This section brings together two elements, first the withdrawal of trade union indemnification for homebirth in 2007 and second the Nurses and Midwives Act which came into effect in 2011[9] The mechanism that apparently 'rescued' homebirth midwifery in 2007 became, as a result of the 2011 legislation, a means by which homebirth midwifery practice could be systematically controlled and restricted.

In 2007, on the recommendation of its underwriters, the Irish Nurses and Midwives Organisation (INMO) trade union withdrew professional clinical indemnification for homebirth midwifery – just as the Royal College of Midwives (RCM) had done in the UK in 1994. In response to concerns at this withdrawal, the HSE in a rushed consultation set up a memorandum of understanding (MOU) with the SECMs which tied State indemnification of their practice to very low risk women only.10 That consultation document is

still not publicly available on the HSE repository site LENUS and many of the issues and recommendations raised in the consultation remain unresolved. The HSE homebirth criteria are more restrictive than those in the UK NICE Intrapartum Guideline regarding choice of place of birth.[11] For example, some women who are seen to have medium risk conditions are deemed by the HSE to be unsuitable for homebirth at all. Some women with other conditions require consultant obstetrician approval for a homebirth, which 'approval' is difficult to obtain. By restricting midwives access to indemnification, the HSE effectively forbids midwives from attending any woman not deemed 'suitable' by the HSE. The HSE thereby dismisses the principle of women's informed choice and entirely ignores women's reasons for choosing homebirth or avoiding hospital birth.

In addition, SECMs have now to have three years post registration experience prior to HSE 'approval' butwithout any indication of the relevance of that experience and without regard to the fact that each midwife at the point of registration must be competent to care for healthy low risk women in any setting. To add further unnecessary obstacles to women's choice the HSE has decided that there must be two such experienced midwives at each homebirth. The HSE has steadfastly resisted SECMs' claim that three years' experience is excessive for a second or on call support midwife. By making its service entirely dependent upon the very small numbers of SECMs in the country (fewer than 20) and by requiring them effectively to 'double up' the HSE hasseriously restricted women's access to its notionally 'national' service[12] as well as seriously restricting SECMs' ability to practice and earn a living. The HSE's stated commitment to choice and flexibility is entirely at odds with its decisions about SECMs' autonomous practice. The HSE acknowledges that there is neither adequacy nor equity in its homebirth service but presents this in terms of resource constraints and safety.

'... the provision of choice in relation to same must be balanced with an overarching concern for safe practice, acceptable levels of risk, evidence-based care and resource constraints.

'It is acknowledged that the proposed system will not immediately provide for equity of access on a nationwide basis. However what it does do is provide a framework that can be applied to enable choice,[10]

Ireland has been a member of the EU since 1970 and so is subject to various EU legislation including directives on midwifery education, regulation and other directives such as those regarding limits to working hours andprofessional indemnification. EU directive 2011/24/EU, on patients' rights in cross-border healthcare, requires health care professionals to have liability insurance.[13]

In 2011, the Nurses and Midwives Act once more recognised midwifery 'as a distinct profession' in Ireland. It however made explicit the requirement that midwives have 'adequate clinical indemnity insurance' (section 40:1a) and criminalised uninsured birth attendance by midwives, resulting in significant fines or imprisonment. Irish midwives (and nurses and doctors) working within HSE hospitals and ser vices are indemnified through the State Claims Agency (SCA) Clinical Indemnity Scheme (CIS).[14]
Demonstration in support of Philomena Canning (SECM) – see also readers' forum (page 25) and news (page 27)

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Midwives, as independent practitioners, are no longer able to obtain indemnification through their trade union membership, or on the open market. Midwives can now only attend women if they accept the MOU and sign a contract to work within the HSE's 'National homebirth scheme'. Furthermore, as the scheme makes provision only for planned homebirth, women no longer have access to SECM-led antenatal, DOMINO or postnatal care.

Cost of compensation now limits birth choice

Financial considerations take precedence over women's decisions. Professional indemnification against claims of financial compensation for loss, has become integral to contemporary definitions of professionalism.[15] The consequences of concern for indemnification reflected in EU directive[13] and Irish legislation[9] were highlighted by High Court Judge Ms Justice Iseult O'Malley in the case between Aja Teehan, a mother seeking a vaginal birth after caesarean section (VBAC) at home (sometimes abbreviated to HBAC) and the HSE which would not provide for it.[8]

'As I see it, the issue of insurance is at the heart of the problem. In the modern era it simply is not possible for medical practitioners dealing with the field of childbirth, whether midwives or obstetricians, to practice without insurance. ... Once that is accepted as a factor, it follows that if a particular ser vice is to be provided, someone must be prepared to bear the potential liability. ... if something does go wrong in childbirth, the consequences may be, not only immensely tragic in human terms, but also extremely expensive in financial terms.'(paragraph 90).[8]

Consideration of financial risk and loss now overlay the already pervasive discourse on clinical risks. Neoliberal market concerns have come, yet again, to be implicated in the control of individual and professional freedoms. In this case, it is the professional autonomy of midwives and the birthing autonomy of individual women that have been restricted. Of most concern, I believe, is that this

restriction has been characterised erroneously, as being in the name of 'protection' of women. Compensation for loss cannot, logically, be considered a protection from harm in the first instance. Women's birth choices (dare I say rights?) have been further restricted by constraining those midwives who would facilitate their choice. Ironically, this constraint is couched in the name of protecting women's need for, and 'right' to compensation.

Women and midwives must stand together

What the legislative requirement for indemnification, and the HSE's monopoly on its provision, have done is to give the HSE almost absolute control over midwives' practice and on terms that neither serve women nor promote midwifery professional autonomy. The HSE has effectively driven a wedge between women who want homebirth and the midwives who would attend them.

I must declare that I am a member of the INMO midwives section, and have been a homebirth midwife (SECM) who has had an MOU with the HSE. I have also served on the HSE National Steering Committee for Home Birth (NSCHB), which 'steers' the HSE homebirth scheme that I have critiqued. It is despite my presence at these various fora and despite my, and many others' representations to the INMO, the HSE and the DoH, that the decisions about the initial withdrawal of indemnification and that subsequent arrangements for homebirth midwifery have taken place. I must accept some responsibility for being unable, then and now, to adequately represent women's, my own and broader midwifery concerns at these developments.

Given the very many and very public cutbacks to government spending including to the health ser vices, the prospect of women's birth choices coming anywhere close to the top of the DoH and HSE agenda seems slim. It is important, however, not only to critique the status quo but to articulate an alternative vision. I believe women and midwives must continue to be represented at the level of maternity policy development. Midwives must continue to stand with women collectively in the perpetual search for decent maternity services.

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