

Change in Maternity Provision in Ireland: “Elephants on the Move”

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Abstract: In an attempt to understand how change can occur in health services this article focuses on two recent developments in Ireland which came about as a result of an unexpected event and a consequent shift in policy which as Hinrichs (2001) and Castles (2010) suggest can be slow to move. Drawing on path dependency theory this article argues that maternity policies in Ireland were “locked in” between 1951 and 2001 in the wake of the Mother and Child controversy, an infamous milestone which led policy to develop along a very specific path and institutionalised the medical model of childbirth which has since endured. During the subsequent fifty years, the size of maternity units increased as did rates of medical interventions. Numbers of women giving birth at home declined from over a third in 1950 to less than one per cent today. This locked in policy for over half a century until it was challenged at the next critical juncture in 2001 when the withdrawal of insurance from two maternity units in the North East of Ireland led to their sudden closure in a region which was the area of greatest population growth in Western Europe. This led to a major shift in the hard to move “elephant” of maternity provision with potential to change policy on a national level in Ireland.

I CHANGE IN MATERNITY PROVISION IN IRELAND: “ELEPHANTS ON THE MOVE”

Social policies once instigated are notoriously difficult to shift (Hinrichs, 2001; Castles, 2010). Developments in maternity service provision in Ireland since 2001, after half a century of inertia and stagnation have the potential to launch maternity policy and service provision in Ireland on a new

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path. Changes and continuities in social policy have been discussed widely by “path dependency” theorists, emphasising the historicity of policy making (Room, 2008). Path dependency associated with the writings of Paul Pierson (2004) holds that critical junctures occur in policy development. Studying these helps us to understand welfare settlements in a nation’s history. Once a policy develops along a certain path, “institutional lock-in” will limit the scope for future change. Such lock-in insures that path trajectories: organisations, institutions and nations are limited in terms of development. Decisions once made will shape and influence policy and politics for the future (Greer, 2008). Present policies have emerged from a historical context whose structures influence present resources and prospects for shaping viable political strategies. The start of a path, taking place in a specific type of situation, often called a “critical juncture” or “breakage point” is often crucially important for subsequent policies. In these critical junctures the development curve transforms into a new trajectory.

This paper argues that maternity policies in Ireland were locked in between 1951 and 2001 following a crisis in Ireland’s history in 1951 known as the Mother and Child controversy, an infamous milestone in Irish social policy and in particular in maternity and infant care which led policy to develop along a very specific path (Kennedy, 2002). The 1953 Health Act which legislated for the introduction of the 1954 Maternity and Infant Care Scheme, institutionalised the medical model of childbirth and hospital based, obstetric-led care in Ireland which has endured since then. During the subsequent fifty years, the size of maternity units increased as did rates of medical interventions such as caesarean section (Brick and Layte, 2011). The number of women giving birth at home declined from over a third in 1950 to less than one per cent today (Kennedy, 2010). This locked in policy for over half a century until it was challenged at the next critical juncture in 2001. This article argues that the withdrawal of insurance from two maternity units in the North East of Ireland and the sudden closure of two maternity units in a region which at the time was the area of greatest population growth in Western Europe was a significant event which led to a major shift in the hard to move maternity policy not only on a regional level but on a national level in Ireland.

II THE FIRST CRITICAL JUNCTURE: THE 1951 MOTHER AND CHILD SCHEME

In 1951 Noel Browne Minister for Health proposed the introduction of a comprehensive Mother and Child Scheme which would have given universal health care to mothers and children for the first time. Ireland was in the midst

of an economic recession, with high levels of unemployment and emigration. Of women giving birth in the Coombe, one of the country's busiest maternity hospitals 75 per cent were anaemic and there was a national tuberculosis (TB) epidemic (Kennedy, 2002). The proposal was heavily criticised by the church and the medical profession who maintained that maternity was a private issue (Kennedy and Einasto, 2010). Subsequently, the proposal was dropped and led to the government's collapse. In Catholic Ireland the principle of subsidiarity was paramount with the effect that motherhood and reproduction were perceived as a private issue. When the state intervened it was in relation to preventing the delivery of services and policy rather than their development. As Michael Solomons, a Jewish gynaecologist who opened the first family planning clinic in Ireland in 1969 wrote:

While the means existed to control fertility, the Irish state lacked the will to allow it ... when it came to the prevention of conception and unwanted pregnancy the Church and the State had the Irish people in a moral and legal stranglehold...meanwhile, the health of women coping with successive pregnancies frequently suffered. When these women looked to the medical establishment for help it was not there (Solomons, 1992, pp. 21-22).

Particular policies may be advocated or opposed for reasons other than their perceived relevance to socioeconomic needs or cultural ideas (Orloff and Skocpol, 1984). The Catholic Hierarchy intervened in 1951 when there was a political move towards introducing universal medical care for mothers and children. This had long term implications (Kennedy, 2002). Article 41 of the 1937 Constitution delineated the role of family and woman in Irish society:

The State recognised the family as the natural primary unit group of Society, and as "a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law". This status of the family hinged to a large extent on "woman" or "mother" who was also endowed with a particularly "favoured" status, which she was expected to live out within the home (Article 41.2).

In terms of mother and infant care in Ireland, 1951 was a critical juncture or fork in the road. Noel Browne's proposed scheme met powerful patriarchal resistance from two sources: the church and the medical profession (Barrington, 1987). The Catholic Hierarchy focused on the principle of subsidiarity, arguing such a scheme would undermine the privacy of the family. This was coupled with a fear of non-Catholic doctors educating Irish

women about such issues as sex, chastity and marriage and a fear of a creeping socialism. Resistance from the medical profession was financially motivated, as doctors made between 70 and 80 per cent of their income from looking after young children and a free service would lead to an increase in salaried doctors (Barrington, 1987). General practitioners in Ireland are self-employed. The rejection of Noel Browne's Mother and Child Scheme shaped maternity services for the next 50 years. It led to the introduction of the 1954 Maternity and Infant Care Scheme following the 1953 Health Act and could be viewed as the first significant move in policy development, or to borrow from Pierson (2004), the first creative move. The next would come fifty years later in 2001. The 1953 Act could be described as a development that shaped maternity policy in the subsequent fifty years. Such institutional lock-in which limits the scope for future policy variation and constrains the trajectory in which nations and policy makers deliver and change can be difficult to instigate (Room, 2008). They tend to favour the well trodden trail (Ebbinghaus, 2005). Thus like elephants (Hinchins, 2001; Castles, 2010), they are slow to shift.

Maternity services are available free of charge to all women in Ireland under the 1954 Maternity and Infant Care Scheme. However, this is only for maternity-related illnesses and only during pregnancy and for 6 weeks following birth. Initially, this guaranteed choice of doctor and for an additional payment choice of hospital or maternity home. Thus, the beginning of the division between home and maternity unit, creating a distinction between those who could and could not pay and as a result home births came to be perceived as the poor woman's option and thus worth less cultural capital. Writing on developments in the UK following the introduction of the 1946 National Health Service Act, Tew refers to the "... changing balance between the competing service providers. It appeared to give mothers more choice, but the new paths were to lead to ever-decreasing choice Propaganda was telling them that doctors were safer and specialists safest of all; after all they had long been preferred by clients who could afford them" (1995, p. 198). While maternal mortality declined from 100 per annum in 1949 to approximately one a year at present, it is important to reflect on how this can often be attributed to place of birth whereas it "... also reflects the improved health and obstetric services, female education, access to hospitals and blood transfusions, as well as an improved social and economic environment" (CSO, 2000, p. 34). These issues are discussed in detail by Tew (1995). In 1955, 33.5 per cent (20,665) of women gave birth at home. By 1970 when the Health Act extended such care to all women, the die was cast and in that year, only 3 per cent (1,883) of women gave birth at home, a very sizeable change in a short period. By 1991 when the Health Amendment Act extended eligibility to all

women regardless of income, 0.3 per cent (178) of women gave birth at home (Kennedy, 2002).

The Maternity and Infant Care Scheme is based on the assumption that ante-natal care is provided by general practitioners (GPs) and obstetricians. This has led to the under-development of midwifery provided/led services. GPs have agreements with the Health Service Executive (HSE) to provide services. The GP provides an initial examination, if possible before 12 weeks, and a further six examinations during the pregnancy, which are alternated with visits to the hospital maternity unit. The schedule of visits may be changed by GPs and/or the hospital obstetrician, depending on medical need. A woman with a significant illness, e.g. diabetes or hypertension, may have up to five additional visits to the GP. Post-natally the GP will examine the baby (not the mother) at 2 weeks and both mother and baby at 6 weeks. Mothers are entitled to free inpatient and outpatient public hospital services in respect of pregnancy and birth and are not liable for any of the standard inpatient hospital charges. Thus, there was no place in the schedule for midwifery-led care up until 2001.

An important feature of maternity services in Ireland is the co-existence of private maternity care. Barrington refers to the Irish health care system as an “extraordinary” symbiosis of public and private medicine (1987, p. 285). Latest figures from the Health Insurance Authority (2009) show that the total market increased from 1,871,000 at the end of 2001, the year the Authority was established, to 2,299,000 at the end of 2008. In 2009, the total market size declined for the first time to 2,262,000. In 2007, 51.2 per cent of the population was covered by private health insurance. An important feature of maternity services in Ireland is the role of private medical insurance in emphasising hospital-based, obstetric-led services. O’Connor indicates that private obstetrics in Ireland is a lucrative profession: “The market for private obstetrics is worth at least 49 million annually; this is divided among the country’s 104 obstetricians...These incomes are further boosted by public salaries (ranging from €125,000 to €150,000) and private gynaecological fees” (2006, p. 110). A review published by the Institute of Obstetrics and Gynaecology recognises that:

The dominance of a medically led, hospital-centred model of care provides effective services for women with non-routine clinical conditions. However, approximately 60 per cent of women experience a normal pregnancy and birth. It does therefore limit the choice for women whose routine clinical needs could be provided for in a wider range of settings (2006, p. 8).

Maternity care has consistently become more medicalised with women in Ireland more likely to experience caesarean section than previously (Brick and Layte, 2011). The caesarean rate for 2008 was 27.3 per cent (Perinatal Statistics, 2008). There has been a trend in Ireland since the 1970s towards larger maternity units. While there are now twenty maternity units in Ireland the Consultative Council on General Hospital Services (Department of Health, 1968, p. 17) estimated there were 169 hospitals in the country providing maternity services. Since the late 1970s smaller maternity units have been closed down as a result of a government policy that all births should take place in obstetric staffed maternity units. There has been a parallel increase in the number of births in larger maternity units. In 1978, 37.7 per cent of births occurred in a unit with more than 4,000 births annually and 30 per cent in units with less than 999 annual births (Kennedy, 2002, p. 86). In 2009 the respective figures were 57.8 per cent and 2.8 per cent (ESRI, 2010, p. 61). In 2008, four of the 20 units accommodated in excess of 8,000 births, over 46 per cent of all births. This has implications for the type of service provided. In recent years several maternity units have amalgamated, for example the Cork University Maternity Hospital (CUMH) established in April 2007 is a purpose-built, modern facility with 144 beds and 12 labour rooms. The third biggest maternity hospital in Ireland, it replaced three former maternity units. The projected 7,500 births per year were exceeded in 2008 when there were 8,725 births at the CUMH (Kennedy, 2010).

In 2006 the Institute of Obstetricians and Gynaecologists completed a review of services in the light of health policy reform which painted a picture of inadequate and flawed services. It reported that maternity provision in Ireland continues to be obstetric-led and is synonymous with the “active management of labour”, ensuring a highly medicalised model of care (DeVries *et al.*, 2001). This is due in part to the way in which the Maternity and Infant Care Scheme has been delivered by GPs and hospitals and also the two-tiered system of medical care where private health insurance offers a lucrative income to obstetricians. The Maternity and Infant care Scheme dictates that women attend their GP as part of their “combined care”. As a result midwifery-led care has been marginalised. In this context women in Ireland have been denied choice in relation to place of birth and type of care provided. This is despite recognition in other jurisdictions that woman-centred care involves informed choice and a variety of options for women. Maternity services have developed in this direction in the UK since the publication of *Changing Childbirth* (1993). Research evidence supports the efficacy of such measures. Hatem *et al.* (2008) in a Cochrane review compare midwifery-led care with other forms of care for women in pregnancy and childbirth and establish there is no significant difference in fetal loss or neonatal death rates and less inter-

ventions and they conclude that most women should be offered midwife-led models of care. The New Zealand maternity system offers women the opportunity to choose a lead maternity caregiver, who may be a midwife, general practitioner, or an obstetrician and 75 per cent of women choose a midwife (Ministry of Health, 2007). In the Netherlands about 30 per cent of women give birth at home and childbirth is perceived as a healthy process by Dutch health care providers, insurance programmes, and the government. Research has described giving birth in the Netherlands from a sociological perspective (DeVries *et al.*, 2001; Johnson and Callister, 2011).

Pierson suggests there are four conditions under which a critical juncture exists. These are “multiple equilibria” under a set of initial conditions conducive to positive feedback, a range of outcomes is generally possible; “contingency”, relatively small events, if occurring at the right moment can have large and enduring consequences; “timing and sequencing” when an event occurs may be crucial, because early steps matter more than later steps and “inertia”, once such a process has been established, positive feedback will generally lead to a single equilibrium (2004, p. 45). This in turn will be resistant to change. These are useful criteria to use in understanding developments in maternity provision in Ireland.

In order for a policy to divert from its path, from institutional lock-in, authority needs to be challenged (Pierson, 2004). This can be particularly difficult when vested interests are strong. In Ireland the power of the medical profession and belief in obstetric medicine is particularly strong (Murphy-Lawless, 1998). The vested interests of the medical profession which were protected remained so until this juncture. Women’s unquestioning faith in obstetric-led services ensured the medical model endured until the status quo was challenged in the late 1990s and gathered momentum in subsequent years. Pierson suggests that road junctures occur when an actor must choose a path, or be forced to choose a path. This is a fateful juncture. Castles (2010, p. 98) drawing on the work of Hinrichs (2001, p. 72) suggests:

... modern welfare states have a massive inertia supplied precisely by the fact that they are an accretion of a vast set of institutional routines established over many, many decades. Like elephants on the move, they are difficult to divert from their course because their size supplies momentum and their institutional routines supply a thick skin impervious to all but the biggest pinpricks applied repeatedly over long periods of time.

Such pinpricks began in Ireland at the turn of this century. Influenced undoubtedly by the publication of *Changing Childbirth* (1993), a major

milestone in the UK which advocated woman-centred care and choice in relation to maternity care for women, in 1996 the first national conference on maternity services was held in Ireland. *Mother and Child 2000: Returning Birth to Women* attracted in excess of 250 participants. Writing on its importance Smyth and Valiulis (1998) state: "... the conference was an important development in highlighting not only the now substantial medical intervention in childbirth but also the structuring of women's experiences of childbirth around the administrative demands of hospitals. There is a growing demand from midwives and other professionals for a more woman-centred approach to childbirth" ("Foreword" in Kennedy and Murphy-Lawless, 1998, p. 1). The 250 participants included birth activists from Aims, the Association for the Improvement of Maternity Services, the Home Birth Centre (now known as the Home Birth Association) and Cuidiú the Irish Childbirth Trust. While little was happening at a policy level, events in the North East Health Services Executive (NEHSE) are a good example of a critical juncture in which dominant ideas and practices were challenged causing a shift in practice.

III 2001: THE SECOND CRITICAL JUNCTURE, SHIFTING ELEPHANTS

At the end of February 2001, when the Irish Public Bodies Mutual Insurance withdrew insurance cover the North Eastern Health Board (NEHB) was forced to suspend maternity services at Monaghan General Hospital and Louth County Hospital. At the same time resistance was stirring in relation to events which were to lead to a public enquiry to investigate the irregular practices over a twenty-five year period of a consultant obstetrician. In September 2003 Dr Michael Neary, a consultant obstetrician at Our Lady of Lourdes Hospital in Drogheda, was struck off the Medical Register following a lengthy hearing before the Fitness to Practice Committee of the Irish Medical Council. He had carried out 129 out of 188 postpartum hysterectomies at the hospital's maternity unit between 1974 and 1988. There is an estimated 250 people involved. Of patients' records 44 went missing, preventing them from taking court action. The region was ripe for challenging the existing status quo. In the wake of the publication of *The Lourdes Hospital Enquiry* (Harding Clarke, 2006), a redress scheme was established to compensate women.

At the time the North Eastern Region of Ireland (North East of Dublin, Counties Meath, Louth, Monaghan and Cavan) was one of the areas of greatest population growth in Western Europe. The total population of the region from the *Census of Population* for the year 1996 was 306,155 and for

the year 2002 was 344,926 and in 2006 the population was 394,098. It is estimated that the population will increase to 432,241 in 2015. This is as a result of migration into the area, partly as a result of the growth of the region as a commuter belt and increased immigration into Ireland and the existence of a major reception centre for asylum seekers in the area. Numbers of births increased from 3,812 in 1999 to 4,778 in 2004 and 6,210 in 2008. This mirrors the national increase in births from 54,307 in 1999 (ESRI, 2002) and 76,021 births in 2009 (ESRI, 2010). Ireland has the highest birth rate of any of the 27 EU countries (17.0 per 1,000 population); the birth rate was 14.4 per 1,000 population in 2000 (ESRI, 2010).

Hospital closures are emotive events for local communities and can spur dormant interest into action. Such was the case in the North East of Ireland. Public outcry and a demand for local maternity services led to the establishment of a Committee to review maternity services in the region under the Chairmanship of Patrick Kinder. This followed the rejection of a first review of maternity services: the Condon Review (2000) when the NE Health Board failed to accept it unanimously and recommended the establishment of a new review group. The Condon Report was rejected by the NEHB, its elected members representing different political constituencies vetoed it as it recommended that consultant-led care in Monaghan and Dundalk should cease in the immediate future as the number of births was "... insufficient to provide consultants with sufficient experience to maintain their own skills or to train on-consultant hospital doctors" (2000, p. iv). The report was also criticised for the very narrow membership of its review group (O'Connor, 2001). Its Chairperson Dermot Condon was a former Secretary at the Department of Health. The other three members were health professionals, two obstetricians and a clinical nurse manager. The subsequent Kinder Review had a membership reflecting a wide range of expertise. Coincidentally, by the time the Kinder Review was established the Irish Public Bodies Mutual Insurances had withdrawn insurance cover for Dundalk and Monaghan so maternity services were suspended temporarily but were never re-opened.

The Kinder Report of the Maternity Services Review Group (2001) is a very important document as it provides a blueprint for a woman-centred, quality maternity service, which is safe, accessible and sustainable. This was the first time such a philosophy was voiced in Ireland since Noel Browne's proposed scheme in 1951. It was a major departure. The second significant departure was that Maternity Services Liaison Committees (MSLCs) were established, for the first time in Ireland. The third major departure was the proposed shape of maternity service, that midwifery-led units be introduced for the first time.

IV CONSUMER INVOLVEMENT: “A COALITION OF REFORM”

Following the acceptance of the Kinder Report by the NEHB in 2001 a Task Force was established to formulate an implementation strategy for the Kinder Review Group’s recommendations. This was a major shift from the path well trodden as it was a direct challenge to existing obstetric services, the norm in Ireland since the fifties. Pierson (2004) writes of the importance of a coalition of reform. This was evidenced in the NEHSE in 2001 in the membership of the Kinder Review. It included four members of the North Eastern Health Board (all elected public representatives, representing Louth, Meath, Cavan and Monaghan), representatives from Patient Focus, the Irish Countrywomen’s Association (ICA), the National Women’s Council of Ireland (which represents 200 groups), the Institute of Obstetrics and Gynaecology, the Faculty of Nursing and Midwifery attached to the Royal College of Surgeons in Ireland, the Faculty of Paediatrics, the Irish College of General Practitioners, the College of Anaesthetists, a Consumer Representative from the Northern Ireland Western Health and Social Services Council, and Chair Patrick Kinder, formerly CEO of the Eastern Health and Social Services Board, NI. Furthermore, its emphasis on wide community participation was exemplary. In 2001, the Kinder Review Group placed advertisements with local newspapers and radio stations inviting interested individuals, groups or organisations to make submissions for consideration. It particularly targeted mothers and potential mothers to consult about the type of maternity service they would wish to have for the future.

Building on this input from consumers in an attempt to develop consumer representation, the NWCI representative and the Chair of the Task Force met with members of an MSLC from the North of Ireland to learn more about how such groups operated. An MSLC is an independent advisory body which consists of representative clinicians from all specialties involved in maternity care, relevant commissioners, manager, public health and social care professionals and user members (Department of Health UK, 2006, p. 4). MSLCS were first set up in the UK in 1984 and further developed during the implementation of *Changing Childbirth* (Department of Health UK, 1993). They were introduced to develop structures and processes through which “... women and their partners are fully involved while using services, in giving feedback about their experiences and views, and in the planning and monitoring of maternity services to ensure that they meet the needs of the local population” (Department of Health UK, 2006, p. 4). The NEHB Maternity Services Task Force was concerned that members would have a real voice and commissioned a research project to investigate such participation elsewhere. It looked to the Critical Appraisal Skills Programme (<http://www.phru.nhs.uk/casp/casp.htm>) developed in Great Britain as a model

which proposes evidence-based health care, encompassing three essential elements: best available evidence; the clinician's expertise, skills and judgement; and the needs and preferences of clients. This was viewed as a useful starting point from which to begin a study of consumer committees. The findings were presented in an unpublished research report: "Establishing advisory committees on women's maternity services for consumers and providers: lessons from experience" in August 2002 (Murphy-Lawless, 2002). To elicit views about the issues outlined above in the context of the NEHB and to explore the idea of the value of an independent advisory forum on maternity services, Murphy-Lawless conducted interviews with potential stakeholders, including: Patient Focus, the Irish Childbirth Trust (Cuidiú) and the Irish Association for the Improvement of Maternity Services (IAIMS). While Murphy-Lawless was conducting the research, there was continued liaison with the Task Force through the National Women's Council of Ireland representative.

Castles asks if the timing of emergency events make a difference to the severity of their consequences (2010). In this case yes. It was opportune as the Kinder report was published in the same year as the 2001 National Health Strategy, a blueprint to guide policy makers and service providers in developing a future health system. Its stated vision was: "A health system that supports and empowers you, your family, and community to achieve your full health potential. A health system that is there when you need it, that is fair and you can trust. A health system that encourages you to have your say, listens to you, and ensures that your views are taken into account" (Department of Health and Children, 2001, p. 10). The principles underlying the Health Strategy are: equity and fairness; a people-centred service; quality of care and clear accountability. It undertook to draw up "a plan to provide responsive, high-quality maternity care". This was coincidentally occurring in parallel with the developments in the NEHSE which served to re-affirm the direction of the Maternity Task Force. Another accident of timing was the implementation of the EU Working Time Directive which led to a shift from consultant-led to consultant provided care. There was a 20 per cent increase in the number of consultant obstetricians and gynaecologists between 2004 and 2010, from 104 to 125 which is 35,674 population per consultant (HSE, 2011).

V A NEW DIRECTION: MIDWIFERY LED UNITS (MLUS)

The Kinder Report's recommendation to establish a region wide maternity service with two midwifery-led units (MLUs) in Cavan General Hospital and

Our Lady of Lourdes Hospital, Drogheda was a major path departure in Ireland where such units did not exist and where the lock-in since 1951 consistently led to obstetric-led care. The MLUs established as a pilot project have a separate identity to that of the established consultant-led delivery unit, with a senior midwife responsible for daily service operation. The philosophy of the MLU is that childbirth is a life-changing event for the whole family, and aims to ensure the safety of mother and child and promote a positive birth experience for all. The MLU provides a programme of family-centred care within a relaxed, home-like and informal environment for healthy women without risk factors for pregnancy and labour; before, during and after normal pregnancy, labour and birth and aims to provide high-quality, evidence-based woman-centred care. There is a strong emphasis on skilled, sensitive and respectful midwifery. The MLUs were evaluated by a research study known as the *MidU Study*, which stands for “Midwifery Unit”. It was undertaken by the School of Nursing and Midwifery at Trinity College Dublin (Begley *et al.*, 2011). The *MidU Study*, a randomised controlled trial was organised and managed by midwives. The results published in 2011 show that the MLU is a suitable environment for all women experiencing a normal pregnancy and labour. However, there are some situations where the consultant-led unit will be the most appropriate place for the woman to have her baby. Between July 2004 and 20 November 2006, 2,260 women participated in the study, randomised across the region (594 Cavan/Monaghan and 1,666 Louth/Meath). This figure includes the 606 women who participated in the pilot study (Begley *et al.*, 2011). The Association for the Improvement of Maternity Services (AIMS Ireland) welcomed the results of the study stressing that it is important that its findings are not reserved purely for policy makers and the academic and clinical audiences of colleges and maternity units in Ireland. “The structure and culture of our maternity services will only evolve if women, as service users, and GPs, as first-line health care professionals, are also educated on the benefits of a social model versus the current paternalistic medical model in normal pregnancy and birth.”

VI FUTURE TRAJECTORIES: ELEPHANTS ON THE MOVE

In Ireland demographic factors have resulted in an increased demand for maternity services. The *2011 Census of Population* demonstrates that the population at 4,581,269 is at its highest since 1861 (CSO, 2011). For the first time Ireland has become a country which has experienced in-migration and has rapidly become a multi-cultural society, raising new challenges for maternity services. The population is expected to grow to 5,820,000 in 2036

(CSO, 2006). The birth rate (number of births per 1,000 of population) in Ireland is 17.0. Ireland is experiencing an unprecedented demand for maternity services with 75,299 live births in 2008 the highest since the 1970s when Ireland experienced a “baby boom” (*Perinatal Statistics*, 2008). Hence, the demand for maternity services will endure. This demographic change has placed increased demands on an already over-stretched maternity service. Despite more than a decade of economic success the health service has remained in constant crisis with many commentators arguing it has worsened (Burke, 2009; Wren, 2003). At the end of March 2012 the health service has a deficit of €145.8 million against a budget of €3.049 billion (4.8 per cent) (HSE, 2012). This coupled with the urgency for the government to make a decision on the location of the proposed National Children’s Hospital has repercussions for maternity services.

The 2001 Health Strategy was concerned with pressures on existing services and undertook to establish a working party “... to prepare a plan for the future development of maternity services’with the objective that maternity care in Ireland in the future would be woman centred; equitable across different parts of the country; accessible to all, safe and accountable” (Department of Health, 2001, p. 84). Attention is currently focused on the Greater Dublin Area (GDA) where in excess of 40 per cent of all births occur annually. What happens here will be a litmus test for the country as a whole. Recent developments in the NEHSE are likely to influence the future direction of maternity services in the GDA and subsequently on a national level well into the future. In 2006 there were 63,237 births in Ireland, of these 36.85 per cent occurred in the three maternity hospitals in Dublin: The Coombe (8,084), The Rotunda (7,235) and the National Maternity Hospital (7,986). The three units are tertiary referral centres for Ireland and, as three training hospitals, the nature of their future development is of national importance. The Greater Dublin Area (GDA) is defined as consisting of Dublin City, Dun-Laoghaire-Rathdown, South Dublin, Fingal, Kildare, Meath and Wicklow. In 1997 a Joint Standing Committee was established to work as a collective body for the three maternity units in the Greater Dublin Area, to facilitate collaboration and to improve the level of care provided to mothers and infants. Developments in the GDA are likely to reflect some of the major innovations introduced in the NEHSE leading to important learning outcomes for the development of maternity services. Models of maternity care are changing, with increasing demands for choice regarding type of care and location. Change has come about as a result of regional responses to local issues as opposed to the national reform agenda. A report commissioned to explore the future development of maternity services in the GDA (KPMG, 2008) indicates that the capacity of the three hospitals is no longer adequate and the hospitals are

under staffed. It states: "... there is an urgent need to increase the level of staffing of consultants and to make changes to consultant work practices to provide cover dedicated to care on the labour ward" (2008, p. 9). This is one area where the GDA can look to the NEHSE for guidance. In changing its maternity service since 2002, the NEHSE had to deal with the challenge of a midwife shortage and in addition a shortage of midwives with experience of midwifery-led care. It also had to deal with changes in consultant work contracts resulting from the EU Working-time Directive. In the GDA there currently is a reliance on consultants, who are delivering private patients out of hours, to provide care for public patients too (KPMG, 2008, p. 9). This is an example of the public/private divide in maternity provision in Ireland. The NEHSE had to deal with this issue when it introduced MLUs as they are a part of the Maternity and Infant Care Scheme and so outside of the private/public split. Developments in the NEHSE have shown the efficacy of a service delivered by midwives. The outcome measures identified by the study are presented under several headings: safety in childbirth, morbidity versus mortality, outcomes for the neonate. A comprehensive list is outlined in the final report (Begley, *et al.*, 2011, pp. 84-90). This is a model which side-steps the issue of consultant delivered care as care is delivered by midwives. It is an important move towards the development of a more equitable service. The NEHSE had to address the sensitive issue of GP contracts in relation to the Maternity and Infant Care Scheme as MLUs emphasised midwifery-led care during the ante-natal period. The Irish system whereby some residents pay the full cost of GP care and medicines and others pay nothing, is unusual in Western Europe – where primary care is generally free or subsidised at a greater level for all residents (Boate, 2011, p. 315). Thus, the fact that maternity care is an exception in that all women can access free care is noteworthy.

KPMG suggest that "Dublin is somewhat out of step with current best practice" (2008, p. 9). Other concerns raised are the emphasis on a hospital-based medical-led model of care, the lack of choice for women and the poor availability of primary and community care services. While the size of maternity unit increasing seems to be a well trodden path which will continue, choice within the unit may take a new direction. The KPMG report recommends that each obstetric unit should have the capacity to deliver up to 10,000 babies, with up to 8,000 in a standard obstetric unit and 2,000 in an adjacent MLU with the MLU being used for deliveries from the outset. In this context important lessons can be learned from developments in the NEHSE. The MidU study has established that midwifery-led care, as practised in the MidU study is as safe as consultant-led care, results in less intervention, is viewed by women with greater satisfaction in some aspects of care and is more

cost-effective. The KPMG report recommends that MLUs should be located on the hospital site adjacent to obstetric units. This has already been achieved in the NEHSE and again can lead the way for those planning and delivering services in the GDA. It is also significant in light of the proposal to build a new National Children's Hospital in Dublin which ideally will be co-located with an acute hospital with a maternity unit. "This will greatly enhance the choices available to women whilst providing the maternity services a more cost-effective means to provide capacity for increased numbers of births" (KPMG, 2008, p. 21). It further states that: "... providing that the midwives in the MLU are experienced and adhere to guidelines, MLUs can provide a safe alternative location for low risk mothers to deliver their babies in addition to the main obstetric unit" (KPMG, 2008, p. 15). Interestingly, the KPMG report argues that the smaller capacity of the maternity units in the GDA contributes to the continued use of the active management of labour. "The current number of deliveries could not be provided without using active management; however that does not mean that it represents best practice" (2008, p. 15).

Demographic factors have put stress on maternity services in the Greater Dublin Area and in the North Eastern Region and this has led to reviews of maternity provision in both areas. The future for the GDA in the present economic climate remains unclear but the current proposals offer a glimpse of a future where women could avail of MLUs and have greater choice and continuity of care in pregnancy. The Health Service has a deficit of €145.8 million and is under pressure to make a decision on the location of the proposed National Children's Hospital and to co-locate it with a maternity unit. Economic context may dictate the future for services in the NEHSE. The findings of the MidU study that MLUs are more cost effective than consultant-led care needs to be seriously considered.

VII CONCLUSION

This paper is concerned with how an unexpected event, the withdrawal of insurance from two maternity units in the North East of Ireland and their subsequent closure has led to significant change in the provision of maternity services in that region. These changes have the potential to lead to further change in the shape of maternity services provision in Ireland as the population continues to grow and even greater demands are placed on services. The initial impact was regional but the long-term repercussions, positive in this case are potentially national, in that they ushered in a new discourse on maternity in Ireland and came at an opportune time when momentum was growing in relation to questioning the efficacy of the

medicalised system in operation and gaining momentum over half a century. This event was sudden and unexpected. In this case the potential population is the 70,000 plus Irish women a year who give birth. At a time, when Ireland like many of its European neighbours are experiencing austerity measures the cost-effective option of MLUs as introduced in the north east of the country as a result of an unexpected event may shift the “elephant” of maternity provision.

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