Can the unequal access to home birth be framed as a source of inequalities? A comparison between Portugal and Denmark[1]

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Abstract

Planned home births happen across Europe, but there are countries where informal and formal limitations can be found by families. This article draws upon a short research project conducted in Denmark in March 2014, which aimed to explore the organization of home birth in Denmark and to compare it to the Portuguese case. Private home births, in Portugal, and publicly funded home births, in Denmark, show interesting similarities when looking at the individual experience of choosing and planning a birth at home. However, through this comparative analysis, I argue that the limitations imposed around the option of home birth in Portugal raise important inequalities between women and families planning to give birth at home and those planning a hospital birth. The successful models found in Denmark can potentially serve as grounds for a broader discussion and as a trigger for change in Portuguese policies, to promote ethical and evidence-based practices among professionals, and the improvement in perinatal health outcomes for families who experience planned home births.

Keywords

home childbirth

health inequalities

reproductive rights

maternity care

organization of care

publicly funded home births

Home births in Europe

Despite the emergence of the hegemonic model of birth at the hospital, planned home births continued to happen across Europe and all over the world. The option of home birth can be framed as a way of rejecting medical dominance and as a strategy to deal with plural risk perceptions that differ from the ones of most health professionals. Some families opt for home birth based on the perception that giving birth is simple, positive and empowering, the rejection of medical dominance and the desire to control the process and to escape the control mechanisms found in hospitals – confinement to bed; the need to fast; permanent foetal monitoring; intravenous catheter; professional paternalism; frequent cervical exams; and the impersonal and artificial environment (Santos and Augusto 2016). In line with Coxon et al. (2014), the perception of a wide range of medical, social and moral risks made it sometimes difficult for parents to cope with the consequences of a home birth, leading to an active search for scientific information and resources – both from conventional and alternative medicines – that legitimate their decisions. Similar results on the personal experience of rejecting medical dominance and managing risk perceptions in-home births were found by social scientists in very diverse European settings, for example, in the Czech Republic (Hrešanová 2010), Finland (Viisainen 2000), Portugal (Santos and Augusto 2016) and Denmark (Kristine Kohlmetz Møller, personal communication, March 2014).

These similarities across countries are exceptional. When comparing legal frameworks, guidelines, institutionalized practices and modes of organization, and access to home birth services by women and families, the cross-country differences are more evident. Several studies address the safety of contemporary, planned home births for low-risk pregnancies, mainly when, for each home birth, adequate referring is offered as part of the health

system, and transfer services are readily available (De Jonge et al. 2013; Snowden et al. 2015). In England, out-of-hospital births overall were revealed to be as safe as hospital births for healthy women with low-risk pregnancies, but with fewer interventions (Birthplace in England Collaborative Group 2011), and this led to significant changes in the organization of maternity care in the United Kingdom. In the Netherlands – with a long-standing, but declining tradition of home births – women at the onset of labour with planned home births showed lower rates of severe acute maternal morbidity, postpartum haemorrhage and manual removal of placenta compared to planned hospital births (De Jonge et al. 2013). It is not always possible to accurately compare planned home births with planned hospital births (Olsen and Clausen 2012), particularly since home birth represents only a small percentage of all births across countries, and many have missing data on this subject (Euro-Peristat 2013).

Nevertheless, the existing evidence could, in principle, be enough for out-of-hospital births to be recommended by health professionals and the state. Today home births are publicly funded across the United Kingdom and in the Netherlands, Iceland, Denmark, the capital region of Stockholm in Sweden and the Italian regions of Reggio Emilia, Modena, Torino and Parma, with some variations in the eligibility criteria and accessibility of midwifery services. Partial reimbursement for home birth expenses is also available in Norway and the Italian regions of Bolzano e Trento, Emilia Romagna, Piemonte and Marche. This is not a comprehensive list as mapping the formal status of home birth in contemporary Europe remains to be done.

Irrespective of the evidence mentioned above, most European countries offer no support to this option, and there are many of these settings where those planning a home birth can

come across significant barriers. In Hungary, for example, due to the lack of legislation regarding midwifery care at home, it was considered illegal up until 2011. Ágnes Géreb, a Hungarian obstetrician, psychologist and midwife, has been an activist on the defence of home births in Hungary and, despite the risk of prosecution, attended over 3500 home births. In 2010, she was arrested and condemned for professional negligence. Within several movements and initiatives that this case triggered across Europe, an application – inaugural in its topic – was submitted to the European Court of Human Rights (ECHR) by Anna Ternovszky on the limitations imposed by her country in respect to her right to choose the place of birth. In the judgement of Ternovszky v. Hungary, it was declared that birth is part of one's private life and, therefore, each woman has the right to choose the circumstances of where to give birth under article eight of the convention (ECHR: 2011: §22):

> The notion of freedom implies some measure of choice as to its exercise. The idea of personal autonomy is a fundamental principle underlying the interpretation of the guarantees of Article 8 […] Therefore, the right concerning the decision to become a parent includes the right of choosing the circumstances of becoming a parent. The Court is satisfied that the circumstances of giving birth form part of one's private life for the purposes of this provision.

The Hungarian government was forced to change the legislation on home births. Since 2011, midwives can apply to a specific licence allowing them to attend births at home legally.

This case raised the debate across Europe on the right to midwifery care and to choose home birth and secured this option with legal legitimacy. However, it was not enough for significant national-level, organizational and professional changes to take place. In Hungary, as in many other European countries, there are substantial risks of litigation for these professionals in the event of an adverse outcome as guidelines for home birth are inexistent or insufficient for protecting professional practices. Recently, in Portugal, a nurse-midwife who assisted home births was charged for malpractice. Given the lack of specific guidelines framing what would be good midwifery practice at home, the hospital practices and guidelines are taken as the standard and the reference by health authorities and the judicial system when assessing the existence of malpractice. Risk is, indeed, very difficult to assess and manage in maternity care (MacKenzie Bryers and van Teijlingen 2010). As hospital birth is framed as the normal, families and professionals involved in out-of-hospital births tend to be marginalized (Coxon et al. 2014). These formal limitations, and the invisibility of access, birth experiences and professional practices in most European countries, highlight the importance of studying home births through the lens of different disciplines, looking at different analytical levels.

Taking the analysis of the legal frameworks, guidelines, institutionalized practices and modes of organization, and access to home birth services in Portugal and Denmark as the point of departure, I aim to discuss how the political decision of keeping home births out of the public maternity systems is defining health inequalities for those who opt for a home birth.[2] Being two European countries, they share the European qualification and legal framework. However, Portugal and Denmark differ in the relative position of home birth in the wider health system, thus enabling a clear comparison between countries.

Methods

To explore the Danish setting, its models of organizing home birth services and the legal and professional framework, comparing it to the Portuguese setting, a short-term scientific mission (STSM) was carried out in Denmark, on March 2014. An STSM is one of the networking tools supported by the European Cooperation in Science and Technology (COST). In each STSM, a visiting researcher is hosted by a foreign institution to collaborate or to learn a specific set of knowledge not available in their home country.[3] This STSM was part of the EU COST Action IS 0907 'Childbirth cultures, concerns, and consequences: Creating a dynamic EU framework for optimal maternity care'.

Within this STSM, there was a combination of several research techniques and different analytical levels. Eight semi-structured interviews were carried out with home birth midwives, midwifery lecturers and home birth researchers with different disciplinary backgrounds on the social, legal and historical background of home births in Denmark. Visiting and briefly observing the professional practice and the interaction with women and families in two different institutions offering home birth services – one in the region of Copenhagen and the other in the Region of Zealand – enabled a comparison between different organizational models existing in the country. Furthermore, the review and analysis of national data, professional guidelines and legal documents were supported by experts at the former Metropol University College, in Copenhagen, now University College Copenhagen.

The review of the Portuguese context on home births, namely the social, legal and historical perspectives around this option was carried as part of an ongoing research project aiming to map this phenomenon in the country. In a first stage, interviews were conducted with eighteen women or families who experienced home births. Later, nine interviews were carried out with professional actors who attend home births, combined with the direct observation of professional practices and interactions, including in two home births.

This combination of approaches enabled the draft of a portrait of the social status of home births in Portugal and Denmark. The description of each national context is presented here individually as two distinct cases with features, followed by a comparative interpretation.

Private home births in Portugal

In Portugal, home births are generally invisible. There are no data on the number of planned home births as the official statistics do not distinguish planned from accidental home births, despite being very different phenomena (Olsen and Clausen 2012). Nowadays, home births represent roughly 0.7–0.8 per cent of all births.[4]

For many years there was a majority of home births across the country, assisted by doctors, midwives, nurse-midwives and traditional birth attendants or *curiosas* ('curious women'). Home birth rates remained relatively high long after the emergence of the hospital. Around 1960, roughly 80 per cent of all births were at home but, in 1985, home births were already rare.

Insert Figure 1 here

Presumably, most of these home births happened with no assistance or were assisted by the *curiosas*, lay but experienced women who played an important part within each community (Carneiro 2008). The professionalization of midwives, emergence of hospital-centrism and decline in home-birth rates in Portugal can be seen as different layers of the same process: a country-level sanitarian initiative addressing the poor performance of maternal and child health indicators – recognized, at least to some extent, as part of the negative social effects of the political dictatorship of that time. It can be said that this initiative was successful – and it still is a common reference in the rhetoric against home birth (Santos 2014) – but it hides the fact that better hygiene, better education, improved access to health care and antenatal care played an important role in these changes in maternal and infant health outcomes (Santos 2012). Also, although the assessment of planned home births' outcomes is limited when looking at infant mortality, rather than perinatal and maternal mortality rates (Olsen and Clausen 2012), the memory of the state's propaganda for an active nationwide effort to reduce infant mortality is still very much present among Portuguese health professionals and decision-makers.

One could question why this is an important issue if there are so few cases of home births. But in fact, being a minority demands an even more responsible and rational assessment. Even though the good results on infant and other mortality rates should be appraised, they cloud the morbidity and the long-term iatrogenic effects of the institutionalization of births within the hospital, and the overuse of interventions to both mother and child. In fact, in 2010, the episiotomy rate in Portugal was roughly 70%, half of the births were operative (i.e. by caesarean, forceps or vacuum extraction), 15% by vaginal instrumental birth and 36% by caesarean section (Euro-Peristat 2013). Indeed, for some of the Portuguese parents who

planned a physiological birth at home, there was either an attempt to escape this instrumentalization of birth or a previous traumatic experience at the hospital (Santos and Augusto 2016).

Now, no Portuguese legislation applies specifically to home birth, although it is not illegal. There is only one formal document related to home births, a brief recommendation produced by the Order of Nurses (Ordem dos Enfermeiros 2012a),[5] with little support of scientific evidence. This recommendation was published together with a press release where it was highlighted that 'specialist nurses in maternal health and obstetric nursing are the best-qualified health professional in Portugal to attend a normal delivery and do not work under medical supervision' (Ordem dos Enfermeiros 2012b). The context of its production can explain this recommendation's limited scope. It seems more of a political statement than a professional guideline as it followed a declaration of the president of the College of Obstetrics and Gynaecology of the Order of Medical Doctors,[6] where he mentioned that nurse-midwives promoting home births were 'people unskilled, with no or little qualifications to attend home births autonomously and much less to assist the new-born'. No other document on the professional attendance of home births was an issue since then.

Along with these tensions and uncertainties, there are informal networks of women and professional actors connecting across the country, defining multiple ways of accessing home birth services. It is an option only available if privately funded – i.e. a woman must hire a midwife out-of-pocket and cover all expenses. Finding and choosing a birth attendant can be challenging as many do not publicly promote their activity; targeting a skilled attendant is thus dependent on each women's social network. Some professionals could be two or three

hours away from the birth setting and, in some cases, they arrived in an advanced stage of labour or after birth.

The referral system is also inexistent. Women often mentioned a hospital transfer as one of the most relevant risks when planning and experiencing a home birth (Santos 2012). In a hospital transfer, there is a great fear of reprisal. In the hospital, given the perception of home birth as deviance, its scarce number and the interventionist model of care, a minor problem is sometimes treated with exacerbated urgency and unnecessary interventions. Besides, being a private service, it is questionable whether the payment has some degree of influence over the decision of transfer, both for couples and for caretakers. When a transfer occurred, or the birth attendant arrived after birth, it was not always clear what the payment would be.

After birth, registering the new-born in a civil registry office can also be challenging, and some families reported having their child registered as having been born in 'other place' rather than at home. This leads us back to the issue of quality of the official statistical data produced on home births. Besides undifferentiating planned from unplanned home births, there is some degree of underreporting that compromises the accuracy of information publicly available.

Publicly funded home births in Denmark

The existence of a legal obligation for each region to provide midwifery care at home sets the ground for better access, more formal practices, more visible networks and better health outcomes for this minority option. Currently, the Chapter 18 of the Danish Health Act

(Ministeriet for Sundhed og Forebyggelse 2010) states that the 'county council provides preventive health consultations by a midwife and the help of a midwife at home'. Home birth is, thus, a publicly funded option. This was mostly possible because of the singularities of the Danish context, where research, the professional development of midwifery and the consumers' demands contributed to an uninterrupted history supporting women's right to choose the place of birth (Santos 2017). Planned home births seem to be increasing, and the rate is now around one to 2 per cent (Lindgren et al. 2014), although some data inconsistency suggests underreporting (Blix et al. 2016).

Some of the families interviewed mentioned having decided for a home birth not to avoid the hospital after balancing the risk perception in each setting, but just because a home birth seemed calmer, cosier and easier. Nevertheless, some families stressed their intention of escaping the interventionist model in the hospital (Kristine Kohlmetz Møller, personal communication, March 2014), similar to the situation in Portugal; yet, there are significant differences between these countries when looking at the professional culture revealed by perinatal health indicators, such as episiotomy and caesarean rates. For instance, in Denmark, in 2010, the same year mentioned for Portugal, the episiotomy rate was 4.9% (the lowest known in Europe), there were 29% of operative births (i.e. caesarean, forceps or vacuum extraction), 7% of births were vaginal instrumental births and 22% of all births were caesarean – 71% were uninstrumented vaginal deliveries (Euro-Peristat 2013). The extinction of some smaller hospitals, in 2007, and the centralization of secondary care in major hospitals – in 2010, about a quarter of all birth happened in units with 5,000 births or more (Euro-Peristat 2013) – was mentioned by health professionals and scholars as

contributing to an increase in the number of interventions, but these remain much lower than in Portugal.

The formal skills of midwives in both countries are similar, but in Denmark they can prescribe and administer medication in case of complications and may also acquire medicines from a pharmacy for home births – including oxytocin for the treatment of post-partum haemorrhage, carbocain for a perineum anaesthesia and vitamin K for the new-born (Ministeriet for Sundhed og Forebyggelse 2014). In addition, informed consent is important both in practice and formally: all women who wish a home birth have the right to assistance from a midwife, even in the case of complicated pregnancies. In this case, midwives must make the woman aware of possible complications and recommend hospital birth, while also being required to provide midwifery care at home according to the woman's decision (Sundhedsstyrelsen 2013), without the risk of litigation in the case of a severe complication that could not be appropriately solved due to the limitations of the home birth setting. Unlike countries where guidelines for the practice of midwifery at home are inexistent or insufficient, in Denmark guidelines are broadly disseminated and protect professionals from liability (Lindgren et al. 2014).

A closer look at the models of home birth in two Danish regions – the Capital Region of Denmark and the region of Zealand – enables a better understanding of some of the singularities of the Danish home birth system.

In the Capital Region of Denmark, which includes Copenhagen, there are midwives assigned to home births within the midwifery teams in the public hospitals. Midwives are hired by the state and work at the hospital in the maternity ward. When necessary, a midwife goes to the woman in labour at home. By visiting a central hospital in Copenhagen and

interviewing homebirth midwives from this city, it was possible to learn about the dynamics of home births teams at the hospital and to discuss its limitations. In 2013, the home birth midwifery team from this hospital attended 112 home births, within a total of around 6,000 births. The transfer rate for primiparous women was 38.9 per cent, and for multiparous women, it was 12.5 per cent.

Some midwives reported that it could be difficult to cope with the uncertainties of such a dynamic, for a team at the hospital, as it was unpredictable when one of the midwives on duty had to leave the hospital ward to attend a home birth. However, when asked about alternatives and solutions, there was a positive vision shared among midwives about this system, and how it was supporting the safety and sustainability of home births in Copenhagen. Moreover, working simultaneously in-home care and hospital care was considered an advantage because midwives could develop skills both in physiological and pathological birth, which was said to continuously train them in the assessment of the need to transfer, and in the treatment of complications, at the same time as it helped to "keep normal births normal" at the hospital, reducing the use of unnecessary interventions in women with healthy pregnancies. Attending home births, altering between these two settings, seemed to sometimes trigger individual activism in the promotion of physiological birth in hospital settings. Nevertheless, hospital transfers tend to be higher in this model (Blix et al. 2016), which suggests that combining home and hospital practice might also lower the threshold for referral in this setting.

In the Region of Zealand, the model is entirely different. The coincidence of historical and personal conditions has ignited the political awareness of the relevance of home birth services in that region (Santos 2016). Visiting this region was a valuable way of contacting

families and home birth midwives in their context of practice. There are now private midwives, working in teams of two, exclusively dedicated to home birth and publicly funded for each childbirth. They are independent workers, but families do not have to pay out-of-pocket for midwifery care at home – midwives are reimbursed directly by the state. This system was mentioned as an example of good practice in-home birth care in Denmark, and the home birth rate in this region is one of the highest in the country: about one-third of all Danish home births.

Midwives in Zealand shared the positive vision of birth with other Danish midwives interviewed. However, they recognized that being entirely dedicated to home births improved their experience and their skills in evaluating and assisting complications at home, which reduced transfer rates. In the event of a transfer, in one setting, where there are good relationships with the hospital teams, the midwife at home follows the woman in labour to the hospital and, in some cases, continues her work with the women in labour there.

Despite these variations, the ways of accessing home birth services are established across the country. There are no evident inequalities between women who choose home births and the ones who plan a hospital birth. There are established practices and guidelines, formal networks both in practice and in research. Transfers are mainly non-urgent and happen in a private car (Blix et al. 2016). Denmark shows to be well positioned in perinatal health outcomes, both alone and compared with other European contexts (Euro-Peristat 2013), and from informal interviews and interactions with couples and professionals, despite some of the concerns mentioned above, there seems to be a feeling of general satisfaction with the way the system of home birth assistance is organized.

Discussion

Table 1 condenses a comparison between home births in Portugal and Denmark, highlighting differences in history, rates, regulation and legal status, professional guidelines, transfers, funding and access to health professionals.

Insert Table 1 about here

Having publicly funded schemes for home births allows the universal coverage of this option in Denmark, safeguarding women the right of choosing the circumstances of birth (ECHR 2011). On the other hand, when only available if privately funded, women who cannot afford to pay for a skilled birth attendant are excluded from this choice, opting for an unregistered attendant at home, a home birth without assistance or conforming to have a hospital birth. In Portugal, even with skilled, registered birth attendants, this combination of factors – the unclear number of registered professionals attending home births; the multiple, informal ways of accessing, hiring and choosing the birth attendant; and the dynamics around hospital transfers – makes home birth an option not as safe as it could be.

Furthermore, many women in Portugal seem to be choosing home births not because that would primarily be their choices, but because the hospital cannot provide the quality of care they expect and consent. Recognizing the legitimacy of home births strictly because there is an overuse of obstetric interventions in the hospital is a widespread reference in the rhetoric around home birth (Santos 2014), but fails to recognize the complexity of this social phenomenon. Improving maternity care in the hospital must indeed be recognized as a

priority, addressing obstetric violence as structurally embedded and naturalized in the organizational culture of health institutions (Sadler et al. 2016), but it is not enough to overcome the issue of inequalities for home birth families. It is questionable whether improving maternity care at the hospital would reduce the rates of home births. It is known that even in settings with publicly funded home births and evidenced-based, national-level guidelines for obstetric and midwifery practice, such as the United Kingdom, a small percentage of women still search for alternatives, such as giving birth at home without assistance (Feeley and Thomson 2016).

Securing the safety of home births, rather than limiting this option, seems to be the most appropriate solution. In a study from the state of Oregon, in the United States, higher rates of perinatal mortality were found in-home births, compared to hospital births; nevertheless, it was recognized that (Snowden et al. 2015: 2652):

> The extent to which midwifery is integrated into a health care system possibly explains some of the differences in practice and outcomes reported in U.S. and European studies. For example, the Dutch home birth system (in which home birth is common and adverse outcomes are rare) includes formal collaborative agreements between out-of-hospital and in-hospital providers, clear and mutually agreed-upon stratification of risk, and protocols for the transfer of care.

This general invisibility of practices, networks and health outcomes related explicitly to home birth raises inequalities between women who plan a home birth and the ones who

plan a hospital birth despite evidence supporting the safety of planned home births – which has resulted in the health services in Australia and the United Kingdom reframing their maternity care policies. The access, the validation of practices and backup support are offered differently: for women who choose to have a hospital birth there is better access to health care, with fewer barriers and fewer constraints; broader discussions and centralized regulation concerning practices; and more efficient and adequate backup support. Given the presented status of home births in Portugal, women who desire to experience childbirth at home will likely face restraints to their right to choose the circumstances of birth.

Conclusion

Private home births, in Portugal, and publicly home births, in Denmark, show interesting similarities when looking at the individual experience of choosing and planning a birth at home. However, exploration of organizational differences between these two countries reveals important inequalities.

Despite the decision of the ECHR on the woman's right to choose the circumstances of birth; the adverse iatrogenic effects of unnecessary obstetric interventions; and the evidence discussing the safety of home births for healthy women with singleton low-risk pregnancies, this is an option only available for a limited group of families in Portugal. While being private and somewhat invisible raises access barriers to families, the inexistence of regulation and institutionalized networks of practice and research restricts the assessment of the quality of care provided in-home births.

Home births have always happened and will continue to happen. These inequalities and the thus emerging ethical issues should be discussed not only at an academic level but also at a broader social and political level. Examples of successful practices and organizations, such as the ones described in the Danish context, could be used as grounds for the discussion and the change of policies in Portugal, promoting ethical and evidence-based practice among professionals and the improvement of health outcomes for families who rationally and reflexively plan a home birth.

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Figure 1: The decline of out-of-hospital births in Portugal.

Source: own calculations from INE/Pordata, available at www.pordata.pt.

Table 1: A comparison between home births in Portugal and Denmark.

	Portugal	**Denmark**
History	The recent history of a majority of home births in a time of poor perinatal outcomes contributed to the widespread prejudice of home births being necessarily unsafe	There is a continuous history of supporting women's right to choose the place of birth
Rates of planned home births	Inexistent. Total rate of home births was 0.7 per cent in 2013, but there is no distinction between planned and unplanned home births	1–2 per cent between 2010 and 2013. Some data inconsistency suggests underreporting
Regulation and legal status	Home births are not illegal, but there is no law or regulation specifically addressing home births	Home births are legal, framed in the law and regulated, within the national health system
Professional guidelines	None regarding home	The national guidelines for

	births	maternity care include information on home birth practice
Hospital transfers	The rates are unknown. Transfers are sometimes delayed due to fear of moral judgement and unconsented care. Several limitations to the continuity of care. Information regarding the onset of labour might be omitted when arriving at the hospital	Mainly non-urgent transfers and mostly in a private car. The continuity of care is assured by the midwife, and in some circumstances, the midwife attending at home can continue with the women at the hospital
Funding	Private (out-of-pocket)	Publicly funded
Access to a registered health professional	Informal and unclear. There is no official list of health professionals who attend home births. Searching for a birth attendant can be challenging. The chosen	Formal and clear. The right to midwifery care at home is stated in the law, and each region must grant access to home births services as part of the official maternity care

	midwife can be several hours away from the place of birth. Unregistered midwives attend some home births	system

Notes

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2 This article is a revised version, with an extended analysis, of a book chapter published in Padilla et al. (2014).

3 More information in the COST website: www.cost.eu.

4 Own calculations, from data provided by the National Institute of Statistics, available at www.ine.pt.

5 The official organization regulating the profession and the practice of nurses, nurse-midwives and midwives in Portugal.

6 With similar regulatory competences as the Order of Nurses, but for medical doctors.