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The Homebirth Association is fortunate to have reached this level of relative strength at a time that the health services in New Zealand are undergoing major changes. If we are smart we can use the present ferment to our advantage. But in order to work out our priorities along with suitable strategies and tactics, we must understand what these changes are and how they came about.

There are two recent official publications which have an effect on the future of homebirth. These are the Department of Health, 1982, Discussion Document, Health Services Reorganisation which resulted in the Health Amendment Act, No 35, 1982; and the Maternity Services Committee (MSC) Report, 'Mother and Baby at Home: The Early Days'.

The Discussion Document (DD) claims that its objective was "to gain improvements in the planning and delivery of health care" based on the concept of area health boards. One of the functions of such boards "would be to support, encourage and facilitate the organisation of community involvement in the planning of health services." (p 15) They would provide "..a forum for a consideration of the plans and aspirations of the private and voluntary sectors, and the means by which consumer's views can be given recognition." (p 13) Before we get starry-eyed it is well to recognise that such boards can be useful in defusing opposition.

The Health Amendment Act proposes appointment of sufficient committees to "cover the full range of health services" (9.18.(1)) Such a committee will replace the professional MSC set up in 1960 and which had its last meeting in June 1982.

The DD asks, what was wrong with the present structure? And answers "its unresponsiveness to changing public attitudes such as the shift towards promotion of preventive and community services." (p 6)

That enlightenment comes from the W.H.O. concept of 'Health for All by the Year 2000'. According to the latest 'Health' Bulletin, people in affluent countries are expected to "rise to their health responsibilities, eating wisely, drinking moderately, smoking not at all, driving carefully, taking enough exercise and learning to live under the stress of city life and helping one another to do so." (p 15, v 35, no 1, Autumn 1983)

You may well ask why this sudden shift from blind reliance on doctors to taking responsibility for one's own health? This is a trend throughout the Western world. Its purpose is to place the burden for ill-health onto the people - a result of their moral failings - and to take the blame off the social, economic and environmental causes. It's called 'the life-style approach to politics', and like all political issues it is basically one of economics. It will continue to allow for high profits in the health care industry by shifting it from nationalised health to the private sector. Just look at the growth of private surgical hospitals and health insurance schemes in N.Z. over the past few years. In fact the DD points out that in the last 20 years the cost of delivering health care has increased by 93% in real terms and much of the growth has been in spending in the ~~xxxxxx~~ hospital sector because of technological change. (p 7)

As N.Z. is predominately a country of 'golden oldies', and 70% of public health expenditure is alloted to personnel, shifting responsibility for the aged onto community/voluntary care could result in large savings.

However, since birth IS a natural physiological function we can turn their rhetoric back onto them. They speak of 'decentralisation', the need for 'flexibility', and the 'organisational unit' that is "not a hospital, a clinic, an office or some other fixed and visible organisation, but a given type of service..." (p 12). I suspect that this was not meant to apply to the maternity sector as the DD intimates that women will deliver in hospital since it makes a concession to G.P.s - they are to have Access to Maternity Hospitals and Wards. (Appendix 11, p 27) This, of course, will stimulate a struggle between the O & Gs (Ogs) and the G.P.s since the Ogs have spent the last 10 years squeezing the G.P.s out of obstetrics. But, at the moment there is a glut of G.P.s on the market, people cannot afford to go to doctors, maternity care is still subsidised by the government and childbirth is the keystone to G.P. practice. We can use that situation to our advantage as it is the G.P.s who are supporting homebirth.

Despite the liberal and progressive rhetoric embodied in the D.D. the MSC Report is unashamedly reactionary and determined to maintain a monopoly on childbirth! As the Wellington discussion submission points out their stance is one of "passive tolerance of a situation which they see as being medically inadvisable." The MSC are, in fact, merely quoting from the document which set this whole investigation into motion. I refer here to the 1980 NZNA, Midwives & Obstetric Nurses Section, 'Policy Statement on Home Confinement' in which they said, "In the absence of positive santions against those who condone and support the trend towards home confinement, the responsibility of the health service is quite clear. Equity of care demands that the health of neither the woman nor her baby be endangered because of her decision". On this basis they formulated policies that admit reluctant acceptance of a fait accompli.... passive tolerance of a situation which had gotten out of their control!

This Policy Statement, prepared and submitted without the approval of the whole membership of the Midwives Section was what stimulated the formation of our Domiciliary Midwives Society (DMS) to speak on our own behalf in our own interests.

The NZNA then followed up their 'Policy Statement on Home Confinement' with a 'Policy Statement on Maternal & Infant Nursing', April 1981. This was prepared by an ad hoc committee established by NZNA National Executive. Although Lynne McLean was listed as a resource person and interviewed once, ~~xxx~~ this was merely a token gesture as she had no part in formulating the 'policy'. The recommendations put forward by NZNA appeared in the MSC draft report word for word. According to the Minister, this report was to have been published in Noc 1982. The Auckland submission obviously caused a rethink, as the present Report is considerably modified. Also, their own membership disagreed with many of the recommendations which were 'railroaded' through their Conference on the basis that they could be debated later. Meanwhile they were submitted to the MSC. I was on the Auckland committee that 'debated' the recommendations. I pointed out that it was an exercise in futili

our comments and criticisms were too late.

When the recommendations came out in November 1983 they were again discussed by the Auckland Branch of Midwives Section, NZNA. I took a copy of the DMS criticisms and comments which were accepted well and adopted with little modification. In fact, in their submission the Auckland Branch (NZNA Midwives Section) said re recommendation no 22 "to attach time regulations (to domiciliary midwives) as a criteria reference is Naive"; and re 23 & 25, "The control of nurses and midwives is properly carried out by senior members of their own profession. These recommendations are clearly discriminatory and could be interpreted as an insult to the nursing profession.'

Menawhile, the NZNA said it was "pleased to see that the Committee has examined and made a number of recommendations relating to home birth. It believes these recommendations are both sensible and practical." (NZNJ, March 1983)

So it is unrealistic to talk about making friends with NZNA. NZNA and HBA are on opposite sides of the fence. Only by giving up the Homebirth option and agreeing to hospital delivery with early discharge could we become 'friends'. But becoming friends with individual midwives (and nurses) is another matter as I have demonstrated with the Auckland Branch of NZNA Midwives Section. Also, a great many midwives feel threatened by NZNA because of the elimination of the basic midwifery training which they have been fighting to have reinstated. They are also threatened by the official NZNA stance that midwifery is merely a post graduate nursing course and not a profession in its own right. This will mean the eventual abolition of the midwifery register. If HBA wants to ~~make~~ make some friends, then support these midwives to maintain the midwifery register and reinstate basic midwifery training; but will further alienate NZNA!

To get back to the MSC Report. This "affirms its position that it cannot recommend the practice of domiciliary confinement" (p 21) on specious grounds: i.e. that in U.K. "the drop in the percentage of home births has gone along with a marked drop in infant and maternal mortality." (p 21)

These are broad and generalised grounds with little relevance to place of birth. Infant mortality is death of a child up to one year from any cause. Maternal mortality is death of a woman from conception to x time thereafter. In U.K. it is one year post partum. Internationally, it is 42 days and in N.Z. it is three months. The causes range from m.v. accidents, malignant disease, medical causes, homicide, suicide, abortion etc as well as obstetric deaths. Obviously, it is only obstetric deaths that are relevant. A N.Z. confidential survey of obstetric deaths between 1969 - 1972 showed that 19.4% of maternal deaths from obstetric causes were the result of anaesthetics and associated causes (12 out of 62 deaths); 18 were due to thromboembolic disease - a condition which can result from surgical procedures and also as a result of the Pill. These figures demonstrate that birth in hospital presents a greater danger than birth at home! The Auckland Branch HBA have arranged to have the Minister of Health asked in Parliament for a breakdown of obstetric deaths over the past 10 years.

This briefly is a backgrounder on the two official documents that affect us. In line with the realities we have to decide our goals and priorities and develop our strategies and tactics.

Nobody would disagree that our main goal is to maintain homebirth as a viable alternative for women who want it. To do this we need domiciliary midwives which means better pay and status. Under the existing legislation we also need G.P.s

At this Conference we need to precisely define our basic philosophy and establish good lines of communication. We need a flexible rather than a structured bureaucratic organisation. Having heard and discussed the achievements and problems in our various areas we are now ready to proceed with this major, but challenging exercise.