Childbirth Practices, Medical Intervention & Women’s Autonomy: Safer Childbirth or Bigger Profits?¹

Maureen Baker
University of Auckland

KEY WORDS: CHILDBIRTH, CAESAREANS, BREASTFEEDING, COMPARATIVE FAMILY POLICY, MEDICAL INTERVENTION, WOMEN

Medical intervention in childbirth is rising in most Organisation of Economic Cooperation and Development (OECD) countries, with the steady increase in caesarean deliveries particularly controversial with the World Health Organisation. Mindful of international guidelines on childbirth issues as well as rising medical costs, states have urged health care institutions to use midwife care for ‘normal’ pregnancies, to shorten hospital stays, and to limit the use of unnecessary technology in childbirth. However, efforts to reform reproductive and maternity services have not always been successful, antagonizing both professionals and women. Based on a larger project about the impact of globalization on family policies, this article demonstrates that international organizations as well as national governments continue to encourage safe childbirth with a minimum of technological interventions and breastfeeding breaks for employed mothers. However, other factors influence childbirth and breastfeeding practices, such as new technologies, changing labour markets, medical and corporate profits and the politics of choice. Childbirth practices are converging cross-nationally, but not necessarily in the direction approved by national governments or international health and labour organizations.

In the past few decades, reproductive and maternity statistics in developed countries have shown considerable cross-national convergence. Maternity care has improved, with 97% of women in these countries receiving prenatal care, 98% having their babies in health facilities and 99% of women attended by a skilled attendant (United Nations, 2000, p. 61). In addition, infant and maternal mortality rates have declined since the 1930s, teen pregnancy and adoption rates have fallen since the 1970s and most partnered women in Europe, North America and Australasia now use contraceptives (UN, 2000; Lewis, 2003; OECD, 2005). More controversial, however, are the rising rates of medical intervention in childbirth and low rates of breastfeeding among certain populations. Medical interventions include the use of amniocentesis, electronic foetal monitoring, anaesthetics, episiotomies, induced labour, elective caesarean deliveries and medically assisted conception (Bosch, 1998; Tew, 1998).

¹ For inquiries, Maureen Baker can be reached at the Sociology Department, University of Auckland, New Zealand. (e-mail ma.baker@auckland.ac.nz)
Medical interventions in childbirth clearly save some lives and marginally increase fertility but they also alter the social construction of childbirth and maternity care. Promoters often use the discourse of ‘safer childbirth’ and ‘more choice for women’ to justify their increasing use of certain interventions. However, these practices empower some women while reducing the agency of others. The increasing use of medical interventions in childbirth also enhances professional autonomy and profits and increases public healthcare costs.

This paper, which uses a feminist political economy framework, discusses four aspects of childbirth practices: professional struggles over childbirth, elective caesarean deliveries, patterns in breastfeeding and the increasing use of medically assisted conception. These issues were selected for discussion because each involves controversies over gendered healthcare practices, concerns about women’s autonomy and wellbeing and attempts by government and international health organizations to regulate, to establish guidelines or to develop minimum standards to protect women and/or reduce public healthcare costs.

Both governments and international health organizations have urged health care institutions to restrict fertility treatment to women with medically diagnosed health problems or genetic diseases, to use midwife care for ‘normal’ pregnancies, to limit the use of unnecessary technology in childbirth and to encourage breast feeding. However, efforts to reform fertility and maternity services have sometimes antagonized professionals attempting to protect their autonomy and profits and led to concerns about women’s autonomy and wellbeing. Attempted reforms have also been impeded by the desire to try new technologies, by medical entrepreneurship, changing labour markets and the politics of choice. I argue that childbirth practices are converging in OECD countries, but not necessarily in the direction approved by health and labour organizations or by national governments.

The paper uses data from a number of industrialized countries to make broad comparisons. It focuses on countries belonging to the OECD because comparative statistics and policy reports are readily available from this organization. In addition, family policies are well established within most of these industrialized countries compared to developing nations. Finally, the original research project from which this paper was based has focused on these countries (Baker, forthcoming).

Safer Childbirth’, Professional Struggles & Women’s Choice

For years, policy makers, healthcare practitioners and parents have expressed concern about the conditions and location of childbirth. Hospitals and/or local governments usually offer prenatal classes and
free medical examinations for expectant mothers and their foetuses and the health costs of childbirth are often paid by the state. State intervention in maternity began to increase in the 1920s and 1930s when infant mortality and maternal death rates were found to be higher in Australia, New Zealand and Canada than in northern and Western Europe (Baker, 2001). Political discussion and policies focused on how these rates could be reduced. Doctors, journalists and social workers expressed concern that mothers themselves were promoting maternity and child health problems by their lack of knowledge about sanitation, nutrition and care during pregnancy (Strong-Boag, 1982; May, 1997).

In the 1930s and 40s, North American (male) professionals began to criticise the knowledge and expertise of mothers, suggesting that the worldly ambitions of the ‘new woman’, who desired education and paid work, would lead to the deterioration of family life (Strong-Boag, 1982, p. 161). Private agencies (such as the Plunket Society in New Zealand) and governments in Canada and Australia produced written advice about pregnancy and childbirth, promoting bottle-feeding and ‘scientific’ infant formula (Kedgley, 1996, p. 56). These governments also established clinics for expectant and new mothers as part of a campaign to reduce infant mortality.

Prior to 1940s, most births took place at home with the assistance of midwives or experienced married women but physicians successfully argued that the sterile conditions of hospitals and medical interventions were necessary for safer childbirth (Tew, 1998). In the United States, less than 1% of births now take place at home, a trend remaining essentially unchanged over several decades (US Department of Health & Human Services, 2002, p. 16). Data on home births in England and Wales show a steady decline from 1961 to the 1980s. In 1961, 32.4% of births took place at home but this rate steadily decreased to a low of 0.9% in 1985 and remained constant at that level through to 1988. From this low figure the percentage of home births increased marginally to 2.3% in 1997 (UK Office for National Statistics, 2002).

In Britain, the increase in home births in the 1990s was attributed in part to the influence of the Winterton Report by the House of Commons Health Committee in 1992, which was followed by the Changing Childbirth Report by the UK Department of Health in 1993. Both reports questioned the proposition that childbirth was safer in a hospital setting and argued that women should be given a legitimate choice between hospital and homebirth, with balanced and impartial information based on sound research and evidence (Tew, 1998). These reports also recommended that midwives should be given the right to manage their own caseloads and to take full responsibility for women under their care.
They argued that home births are as safe, if not safer, than hospital births for women with ‘normal’ pregnancies. In addition, they noted that home births involve lower rates of medical intervention and are less costly (Tew, 1998).

However, the slow growth of home births in Britain throughout the 1990s disappointed advocates (UK Office for National Statistics, 2002). As the average age of first births has risen, the medical profession has been able to argue, quite successfully, that older births represent higher risks and should therefore take place in hospitals with the necessary technological and medical assistance.

In New Zealand, the Nurses Amendment Act in 1990 restored autonomy to midwives who were previously limited by legislation that allowed medical practitioners only to take full responsibility for childbirth (NZ Ministry of Health, 1990: 1). However, while midwives attend an increasing number of births in most of the liberal welfare states, obstetric interventions continue to increase (UK Government Statistical Service, 2003; NZ Ministry of Health, 2003; US Department of Health & Human Services, 2003). This suggests that physicians control the birthing process even when midwives are present.

Neo-liberal restructuring has also influenced the organization of maternity services in recent years. Health care services in both Canada and New Zealand are being regionalized and responsibility is being shifted from public institutions to informal networks and unpaid caregivers (Armstrong et al., 2002; Barnett & Barnett, 1999). In some regions, health service delivery and planning has moved from the core to the periphery, with greater emphasis on local control and decision-making. Benoit, Carroll and Millar (2002) argued that non-urban women in British Columbia view the recent regionalization of maternity care services in a largely negative light. Women emphasize the lack of choice in care providers, discontinuous care across the birthing period, inadequate quality of care and lack of opportunity to have a voice in local health care planning. However, many politicians believe that regionalization and privatization can reduce the cost of health services.

Public expressions of concern about the bureaucratization and medicalization of childbirth have forced hospital administrators to become more cognisant about parental choice and have led to the development of more pleasant birthing rooms in local hospitals. Private ‘birthing centres’ offer some luxuries to patients who can afford them, but they also tend to focus on cost efficiencies. In the 1940s and 1950s, women could expect a two-week ‘confinement’ in hospital, but now, they are expected to leave in a few days. This short stay is justified for health reasons, but also serves as a cost cutting measure (Tew 1998).
Controversies continue about the licensing of midwives and who controls the childbirth process. Physicians, midwives and women all want more choice in maternity services, but women also expect continuity of care throughout pregnancy, childbirth and the early months of motherhood. While governments struggle to reduce healthcare costs, new childbirth practices are increasing costs. One of the most contentious is the rise in caesarean deliveries.

The Rise in Caesarean Births

The rise in induced births and caesarean deliveries has been noticeable in many countries, influenced by women’s older age at first birth, the perception of older births as ‘high risk’ and efforts to gain control over the timing of birth (Bosch, 1998; Health Canada, 2000, p. 23; Jones, 2005). In the ‘liberal’ welfare states (Esping-Andersen, 1990), 20 to 26% of all births are induced and 21 to 26% of all births are caesarean deliveries, as Table One indicates (Baker, forthcoming). In Britain, the proportion of women giving birth by caesarean section has increased from 4.5% in 1970 (Jones, 2005) to 22% in recent years.

Many health organizations, feminist groups and professionals believe that increasing rates of caesarean births are undesirable and unsustainable. For example, the World Health Organisation suggests that the optimum rate is between 5 and 15% of all births (WHO et al., 1997, p. 77) but few countries show rates below this level. In fact, the rising rate of caesarean births have become one of the most contested issues in maternity care today. Many of these operations are viewed as unnecessary surgery that cost three times more than vaginal births and involve more medical complications (Tew, 1998; Walker, Turnbull & Wilkinson, 2002).

Table I: Birth Statistics in Selected Countries, late 1990s-2002

<table>
<thead>
<tr>
<th>Country</th>
<th>Induction of Labour as % of Births</th>
<th>Caesarean Sections as % of all births</th>
<th>Infant Mortality Rate by Sex</th>
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<td>Canada</td>
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<td>Australia</td>
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<td>New Zealand</td>
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<tr>
<td>United Kingdom</td>
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<td>United States</td>
<td>20.6</td>
<td>26</td>
<td>6</td>
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<tr>
<td>Sweden</td>
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<td>Netherlands</td>
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In Canada, caesarean deliveries have increased since 1991, but rates vary considerably by province, averaging about 21% of all births (Health Canada, 2003, p. 34-35). In New Zealand, caesareans have also increased in recent years to about 22% in 2001 and social class and ethnic differences are readily apparent in these statistics. For example, Asian and European women, who have the highest incomes in New Zealand, also have the highest caesarean rates and indigenous Maori women have the lowest incomes and lowest rates. The caesarean rate also increases with age and was over 33% for women aged 40 and older in 2001 (NZ Ministry of Health, 2003). Particularly elective caesarean sections increase with the mother’s age. In 2001, over 15% of mothers aged 40 or older had elective caesarean deliveries compared to 2% of mothers who were under 16 years (NZ Ministry of Health, 2003, p. 36). In Australia, 21.9% of births were by caesareans but for women aged 40 and over, the percentage rose to 37.6 (Ford et al., 2003, p. 107).

The caesarean rate is also rising in the United States and in 2002 reached 26.1% of all births. Ethnic variations, related to socioeconomic status, are also apparent in the American birth statistics. For example, Afro-American mothers are less likely to have caesarean births, but far more likely than White or Hispanic mothers to have preterm, ‘very preterm,’ low birth-weight and ‘very low birth-weight’ babies (US Department of Health & Human Services, 2003, p. 89). American government reports also indicate that after one caesarean birth, mothers are far less likely to experience vaginal births with subsequent children (US Department of Health & Human Services, 2003, p. 2).

Considerable research suggests that neonatal mortality rates and childbirth complication rates tend to be lower in jurisdictions where health practitioners perform fewer caesarean sections, where midwives provide continuity of care and where midwives are permitted to attend both home and hospital births (Jezioranski, 1987, p. 100; Papps & Olssen, 1997; Tew, 1998). In New Zealand, about 73% of mothers used midwives at birth, 9.6% used general practitioners and 17.3% used obstetricians in 2001 (Papps & Olssen, 1997, p. 116). Those using midwives had the lowest rates of both acute and elective caesarean sections.

High-risk births, however, are referred to obstetricians within hospitals, which raise the neonatal mortality rates of hospital births by obstetricians compared to home births by midwives. Yet even with normal births, midwives are less likely than doctors to rely on technological monitoring, drugs and other interventions. Consequently

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2 An elective caesarean section is performed before the onset of labour, whereas an acute caesarean section is performed urgently for maternal or foetal health reasons once labour has started.
the clients of midwives require less postpartum care and recovery time (Fooks & Gardner, 1986, p. 7; Tew, 1998). In addition, midwives cost less public money than general practitioners and especially obstetricians and for this reason some jurisdictions include midwives in the public health care system and support midwifery training programs (Baker, 1995, p. 361).

Many studies find that women receiving maternity care in private hospitals rather than publicly-funded ones are more likely to give birth through caesarean sections (Roberts, Tracy & Peat, 2000; Walker, Turnbull & Wilkinson, 2002). Australian research reported that women admitted as private patients have a higher caesarean rate than public patients: 29.5 per 100 confinements compared to 19.0 (Ford et al., 2003, p. 107). The suspicion that obstetricians may prefer induced labour and caesarean sections because they can control the timing of a birth is supported by British data showing that births which are induced are most likely to occur between Tuesday and Saturday and in particular not on Sunday. Caesareans are extremely unlikely to take place on Saturday or Sunday, but spontaneous labour shows very little variation between days of the week (UK Government Statistical Service, 2003). US data show similar trends (US Department of Health & Human Services, 2003).

The higher percentage of caesarean sections performed on wealthier private patients cannot be explained by an increased percentage of higher risk pregnancies. Walker, Turnbull and Wilkinson (2002) suggest that more research is needed to establish why caesarean sections are more prevalent in private health settings. I would argue that wealthier women seek out care in private hospitals because they believe that they provide better quality health care as well as patient services. Women request or permit induced labour or caesarean sections because they are told by doctors and websites that they are safe and offer more control over the birthing process.

Increasingly, wealthy women are requesting elective surgery and there is some suggestion in the media that this includes caesarean deliveries as well as cosmetic surgery. Elective caesareans certainly allow more choice about the timing of birth but some doctors also promote them as safer from a medical and legal viewpoint (Jones, 2005). In addition, women are encouraged to believe that elective caesareans will improve the health of their pelvic floor, preventing later incontinence and will improve their sexual pleasure after childbirth or keep them 'honeymoon

As food for thought, Dworkin (1974) pointedly asks us to consider the immobilizing and deforming effects of modern killer shoes with sharpened toes and ridiculous heels before expressing our aversion to the ancient Chinese practice. Of course, Dworkin’s goal is not to make light of the foot-binding practice, but to show the continuation of beauty myths that target women’s body, freedom and choice.
The idea presented in the media that some rich women are ‘too posh to push’ erroneously suggests that the rise in caesarean births is generated by women pressuring their doctors to perform these operations (Asthana, 2005). In fact, few doctors and hospitals provide major surgery ‘on demand,’ although some private clinics perform lucrative elective surgery on request, especially in the United States. Some physicians also argue that it is safer to perform an elective caesarean than an emergency one and that clinical guidelines about when to perform caesareans are not always clear (Asthana, 2005).

The World Health Organisation has urged governments and hospitals to reduce the rate of caesarean deliveries (WHO et al., 1997, p. 77) but some regions, including parts of India and South America, show rates between 25% and 45% (Walker, Turnbull & Wilkinson, 2002, p. 28). In contrast, the rates in the Netherlands and Sweden have remained at about 10% since the 1980s (p. 29). Both these countries provide extensive prenatal care, while the health care funding system in the Netherlands requires normal births to be midwife attended and to take place at home (Tew, 1998). These two countries also have among the lowest maternal and infant mortality rates in the world, also shown in Table One. The examples of the Netherlands and Sweden show that governments can control caesarean rates if they have the political will.

In contrast, other states have enacted less effective strategies to lower the frequency of caesarean deliveries, which they associate with increased maternal health risks, longer hospital stays and additional public costs (Walker, Turnbull & Wilkinson, 2002). In Canada, for example, clinical guidelines have been established for caesarean deliveries and efforts have been made to encourage women who have previously experienced a caesarean to attempt a vaginal delivery in subsequent births (Health Canada, 2000, p. 21). In Australia, a global obstetric fee was introduced in 1998 to attempt to reduce caesarean deliveries in that country, but without success (Walker, Turnbull & Wilkinson, 2002, p. 37). Clearly, caesarean deliveries offer both physicians and women more control over the timing of childbirth. They are often seen as safer for older mothers and bring higher fees to professionals and hospitals.

After childbirth, governments and healthcare practitioners typically encourage new mothers to breastfeed. However, this has become increasingly difficult as more women work in globally competitive labour markets, in jobs that promote an ‘overtime’ work culture with fewer statutory breaks.
Breastfeeding Policies & Practices

Breastfeeding is associated with numerous health benefits such as providing optimum nutrition for infants, reducing the incidence and severity of infectious diseases and lowering infant mortality (WHO & UNICEF 1990). According to the World Health Organisation (2003, p. 5) malnutrition has been responsible, either directly or indirectly, for approximately 60% of the estimated 10.9 million deaths annually among children under five across the globe. More than two thirds of these deaths occur during the first year of life, many of which are associated with poor feeding practices (WHO, 2003). Breastfeeding is also an effective means of spacing children, so for decades both WHO and the United Nations Children’s Fund (UNICEF) have emphasised the importance of breastfeeding for childhood health (WHO, 1981). Studies also suggest that mothers who breastfeed enjoy a reduced risk of breast cancer and possibly ovarian cancer and osteoporosis (Galtry, 2003).

In 1974, the 27th World Health Assembly noted a general decline in breastfeeding in many parts of the world (WHO, 1994). They related this trend to a wide variety of socio-cultural factors including the promotion of commercially manufactured breast-milk substitutes. The Assembly thus urged member countries to review and “where appropriate” to regulate sales promotion activities on baby foods, through advertisement codes and legislation (WHO, 1981, p. 4). In 1981, the 34th World Health Assembly adopted the International Code of Marketing of Breast-milk Substitutes which aimed to “contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution” (WHO, 1981, p. 8).

The Code asserted that due to the vulnerability of infants and the risks associated with inappropriate feeding practices, the marketing of breast-milk substitutes required special regulatory attention (WHO, 1981, p. 7). The WHO and UNICEF also introduced the Baby-Friendly Hospital Initiative in 1991 to encourage maternity facilities to become active supporters of breastfeeding practices and to abandon the use of breast-milk substitutes (UNICEF, 2004).

One of the factors influencing the duration of breastfeeding is the length of maternity leave and the provision of breastfeeding breaks and facilities for employed mothers (Galtry, 2003). The International Labour Organisation (ILO, 2000a) adopted its original Maternity Protection Convention in 1919, recommending 12 weeks leave with cash benefits to ensure continuity of income, protection against dismissal during leave and two half-hour daily breaks for nursing infants (ILO, 2000b). In 1952,
the revised Maternity Protection Convention extended leave entitlement to cover illness resulting from pregnancy and expanded upon the types of medical benefits provided (ILO, 2000b). It also specified that nursing breaks be paid and counted as working time (International Baby Food Action Network, 2000). Under the latest Maternity Protection Convention (no.183 in 2000), women are entitled to a daily reduction of working hours with full remuneration for breast feeding and more categories of women workers are now covered under the Convention (ILO, 2000b).

The European Social Charter of 1996 also contains provision for paid maternity leave or social security benefits for a minimum of 14 weeks, increased from 12 weeks in the original 1961 Charter (Council of Europe, 1961 & 1996, Article 8). The current Charter also stipulates that nursing mothers shall be entitled to adequate time off for this purpose. However, some OECD countries have not ratified the ILO Convention and some European countries have not signed the Social Charter.

National and state governments also encourage maternity and breast feeding leave for employed mothers. Although women know that breastfeeding is important for infant health, more now work in high-pressure jobs in competitive and global work environments. Despite international agreements and national entitlements to paid leave, the prevalent work culture under these employment conditions sometimes discourages childbirth as well as breastfeeding. Cross-national differences in the prevalence of breast feeding are partly influenced by women’s employment rates, their access to paid leave and public education programs about the importance of breast feeding. However, they are also related to social class and ethnicity (when it correlates with class).

Although breastfeeding increased in Canada throughout the 1990s to about 82% of children under two years old, younger mothers with lower levels of education are less likely to breastfeed their babies (Health Canada, 2003, p. 13). Women from low-income households are also more likely to be employed and less likely to have control over their working conditions. In New Zealand, nearly 80% of mothers breastfeed their new babies, either exclusively or partially, but Maori mothers are least likely to breastfeed exclusively (NZ Ministry of Health, 2003, p. 70).

Although low-income women used to be more likely to breastfeed their infants than wealthier women, breast feeding may have become a middle-class phenomenon in some countries. This is especially the case where women from low-income families must remain in the workforce and accept jobs with lower levels of control over their employment breaks and leave time. Another middle class phenomenon is the increasing use of medically assisted conception.
Medically Assisted Conception

Fertility problems seem to be on the rise in OECD countries but like family violence, this apparent increase partially reflects new reporting procedures. Fertility clinics have become readily available and sexual issues are more openly discussed, encouraging people to seek medical assistance with their conception problems. Also, low fertility is correlated with factors related to urban living, such as environmental pollution and high stress levels, as well as cigarette smoking, alcohol abuse, sexually transmitted diseases and prolonged use of birth control pills (Adair & Rogan, 1998; Coney & Else, 1999). Conception problems also become apparent as the age of marriage rises and older women try to conceive. This suggests that low fertility is becoming more prevalent.

The portrayal of reproductive technology as new, experimental or potentially dangerous has shifted and it is now regarded by many as mainstream medical practice. Several researchers have examined popular representations of medically assisted reproduction, showing that they appeal to scientific progress, medical expertise, humanist cures for disease and the politics of choice. All these representations help to normalize these technologies (Albury 1999, Franklin 1995). Both Bharadwaj (2000) and Van Dyck (1995) argue that the discourse used within medicine and journalism are complementary, with the media are shown to be a key site through which assisted reproduction has been legitimated.

Despite this normalization and legitimization, fertility treatments can be expensive, disruptive and time-consuming for women and couples, involving several clinic visits each treatment week and drugs that alter normal functioning. As techniques have been perfected, success rates have increased. However, misunderstandings have been possible by clinics presenting pregnancy rates to their potential clients rather than live birth rates, despite the fact that miscarriage rates for such procedures are about 25% (Baird, 1997). British and Australian research indicates that in vitro fertilization (IVF) ends in success for less than a third of those who embarked on it (Doyal, 1995) and only 15% per treatment cycle (HFEA, 1997; Ford et al., 2003). In Australia, the viable pregnancy rates were 14.9% after one cycle of IVF, 15.9% for insemination with sperm, and 18.1% for egg transfer. If these products are frozen or thawed, the pregnancy rates fall (Ford et al., 2003). Australian research also shows that adverse infant outcomes, such as pre-term delivery, low birth weight, stillbirth and neonatal death, are higher among assisted conception births compared to all births (Ford et al., 2003).

Governments typically distinguish between medically necessary interventions and those requested for social reasons. Consequently,
people with no medically diagnosed reason for infertility or who are not at risk of passing on a genetic disease may be deemed ineligible to receive publicly funded services. Yet in pronatalist societies, a high value is placed on ability to reproduce and those who cannot conceive sometimes feel excluded from normal adult life. In my New Zealand research, some couples undergoing fertility treatment said that the medical interventions designed to solve their fertility problem made them feel socially excluded because treatment was usually kept secret from relatives and co-workers, it interfered with their daily functioning and was unaffordable (Baker, 2004).

More people are now seeking medical assistance for conception problems but international health organizations have created few guidelines or multi-country agreements about access to treatment. However, national and state governments have been developing new laws governing eligibility for publicly-funded services, how long treatment should continue and access to information about donors from future offspring. Many of these issues have already been contested in courts but the speed of change in genetic research and reproductive techniques has moved faster than the law. Meanwhile, some doctors have been making healthy incomes from fertility procedures, offering prolonged treatments to women with very low probability of success (Baker, 2004). Despite restrictive legislation in some countries about the use of public resources for fertility treatment, wealthier patients are often able to purchase conception assistance in private clinics or travel to other jurisdictions with less stringent regulations. This suggests that these lucrative but experimental services offer wealthier women greater choice about motherhood while poorer women have less access to these technologies.

**DISCUSSION & CONCLUSIONS**

Childbirth trends and practices are converging in OECD countries, influenced by the rising age of first birth, the development of new technologies, labour market changes, less marriage stability and neo-liberal restructuring of health services. Young people are delaying reproduction until they complete their education and find permanent work with wages high enough to afford the rising cost of housing and childrearing. Marriage instability encourages others to postpone their attempts to have a child (Weston et al., 2004). Labour market changes make it increasingly difficult to take time off work for pregnancy and

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3 In vitro fertilization costs between $8,500 and $12,000 per month in New Zealand.
breast feeding, despite new leave policies promoted by the International Labour Organisations, the European Union and individual governments. More people are seeking assistance with conception as they become aware of new fertility clinics. Medical interventions are increasingly used in childbirth as new technologies enable doctors to prevent negative birth outcomes and make the childbirth process more efficient.

Governments and health care organizations create their own childbirth policies, but we have seen that international organizations, such as the WHO and the ILO also urge national governments to sign international agreements to ensure access to reproductive services, safe and cost-effective childbirth practices and paid employment leave for childbirth and breast feeding. Despite these agreements, childbirth policies and practices are more often influenced by other factors, including neo-liberal restructuring, domestic professional rivalries and different political views about healthcare options.

Neo-liberal restructuring has been encouraged by the promoters of economic globalization, including the OECD (Mishra, 1999). Governments have also become mindful of increasing healthcare expenditures with growing concern about population aging, the rising cost of medical equipment and higher health-related salaries at a time when many voters expect lower income taxes. Consequently, policy makers have encouraged health care providers to limit fertility services to those with medically diagnosed problems, to use midwife care for normal pregnancies, to curb the use of unnecessary technology in childbirth, to shorten the duration of care in hospitals and to reduce home visits for new mothers. However, efforts to save public healthcare expenditures have not always reduced public costs. Instead, the development of user fees has increased costs to patients and healthcare service cuts have encouraged higher income families to purchase services from private providers whenever possible (Armstrong et al., 2002; Barnett & Barnett, 1999; Benoit et al., 2002). Furthermore, government cost-cutting efforts have sometimes antagonized both professionals and patients who feel that patient care is being jeopardized. Physicians and midwives also worry about loss of job control and professional autonomy.

Neo-liberal restructuring has promoted the rise of alternative delivery mechanisms, such as private clinics where health care practitioners offer a range of services to patients who are able and willing to pay. Unclear procedural guidelines, especially in private clinics, have enabled some physicians to convince pregnant women that foetal monitoring and induced labour are necessary procedures, even when these women prefer not to use them. Some physicians have also promoted elective caesareans, persuading pregnant women that they provide safer
Some women also press their doctors for healthcare services they believe are necessary or desirable, based on their available sources of information or beliefs. For example, in my fertility study I found that a few women insisted on continuing with expensive private treatments and were permitted to do so even when they were told by medical staff that the probability of success was negligible (Baker, 2004). Other women may request elective caesareans to alleviate the unpredictability timing, the pain and some of the side effects of childbirth. Many women choose to bottle feed their children because their busy work schedules or concerns about the side effects discourage breast feeding. Some of these practices may increase women’s feelings of control over childbirth but they also tend to medicalize the experience of childbirth. These practices also increase healthcare costs for patients but also for the tax-payer if unexpected problems occur and women or their newborn infants are sent to public hospitals (Baird, 1997). At the same time, profits can obviously be made from reproductive interventions as well as the marketing and sale of infant formula.

In terms of professional rivalries, doctors and midwives struggle for control over childbirth, as do obstetricians and general practitioners. Midwives promote women’s right to home births and continuous care from pregnancy until several months after childbirth. They argue that childbirth is a natural act that should not be medicalized or controlled by physicians but that women benefit from the presence of a supportive and qualified midwife during childbirth. General practitioners encourage continuous care by family doctors and hospital births.

On the other hand, many obstetricians believe that delivering babies should be confined to specialists who understand the risks and can effectively handle the new technologies to monitor and improve childbirth outcomes. They view births to ‘older’ mothers as ‘risky’ and strive to provide quality care using the latest interventions (Tew, 1998). All three parties endeavour to protect themselves from malpractice lawsuits, to preserve their working conditions, and to retain professional control. Fertility specialists and obstetricians tend to use the most interventions and to develop the most lucrative practices (ibid). In the liberal welfare states, the medical specialists have become a powerful lobby in the childbirth process despite the state’s desire for cost-cutting measures.

In addition, different views on the morality of assisted conception, increased technological intervention in childbirth and breastfeeding

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4 In my New Zealand research involving qualitative interviews with 25 people, two women who were 44 and 46 had been undergoing treatments for several years at great personal expense, even though they were told that the probability of success was less than 5% (Baker 2004).
continue to confront doctors, hospital administrators and policy makers (Jones, 2005). Feminist groups have fought for women’s right to control their own bodies, and for women’s right to combine childbirth, breast feeding and children’s needs with paid work. On the other hand, social conservatives seek to ensure that procreation takes place within committed and legal heterosexual relationships, that married couples continue to reproduce the next generation, and that family formation does not interfere with corporate profits in the competitive global labour market. Some politicians still see reproduction as a social and patriotic duty and strive to ensure that declining fertility does not interfere with the country’s ability to finance social programs in the future (Dodson, 2004).

These economic, professional and socio-political factors tend to counter the efforts of healthcare institutions and practitioners to provide safe, necessary and cost-effective childbirth practices and to enable women to reproduce and breast feed their infants while earning a living. This paper has shown that childbirth practices are converging cross-nationally because they are influenced by similar social trends. However, these practices are not always changing in the direction desired by governments or international health and labour organizations. Instead, conception, childbirth and breastfeeding have become even more governed by employment conditions, neo-liberal restructuring, the politics of choice, rivalries among health care practitioners, and patients’ ability to pay.
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