# Chapter 6

# Maternity Care as a Global Health Policy Issue

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## Introduction

Governments play a crucial role in defining what is 'maternal health' and deciding what services are included in maternity care delivery. State policies also shape the roles of formal and informal care providers, families, the public, and commercial and voluntary sectors in providing maternity, as well as newborn and reproductive healthcare services. Reducing health inequities for pregnant women and increasing their access to quality maternity services have been foci of global efforts to realize the right of every woman to the best possible maternity care. In the last half century, most high income countries have publicly invested in universal healthcare (UHC) coverage for their respective populations, which has include comprehensive maternity care. More recently, several low-to-middle income countries have likewise been investing in universal healthcare coverage.

Yet a parallel expansion of 'neoliberal' healthcare reforms during the recent decades is worrisome. Such neoliberal reforms, while initially deployed in regulated and unionized labour markets, have increasingly involved commercialization and/or privatization of healthcare services, including midwifery care, and maternity care services in general (Benoit et al., 2010). The outcome of these neoliberal reforms is often in conflict with the purported social-democratic

ethos of global health policy as expressed in the Millennium Development Goals (MDGs) issued by the United Nations (United Nations, 2012). In fact, of all the eight MDGs, there has been least progress toward the realization of the global right of every woman to the best possible maternity care.

This chapter focusses attention on these current paradoxical issues, drawing on four distinct case examples selected from low-resourced to middle- and high-resourced countries – Nepal, Chile, Canada and England. These countries provide examples of different institutional contexts, but all sharing the fact that healthcare has been subjected to saliently neoliberal reforms that emphasize cost containment through efficiency, and views healthcare provision as production of commodities for private markets or quasi-markets. We illustrate substantial diversity within and across these countries regarding universal healthcare coverage, effective midwifery workforces, welfare state policy in improving maternal health, private sector involvement in care provision, and women's right to maternity care.

## Maternal healthcare policy in global perspective

MDG 5, *Improve Maternal Health*, aims to reduce maternal mortality ratio by three quarters between 1990 and 2015. The goal uses two indicators to measure whether or not the target has been achieved: the maternal mortality ratio (MMR) and, by 2015, universal access to reproductive health (WHO, 2010). The latter involves increasing access to antenatal care, reducing teen pregnancies, expanding access to family planning, and increasing contraceptive use.

The post-2015 development agenda for MDG 5 provides a unique moment in time to ensure that the barriers to improved health for women and children health is placed firmly on the global

agenda (Quick et al., 2014). These barriers involve unequal access to quality healthcare for these populations when compared to other groups within and across countries (Graham et al., 2013; van Teijlingen et al., 2014). While recent initiatives such as 'Every Woman Every Child' (United Nations, 2010) and the 'Global Newborn Action Plan' (PMNCH, 2014) have given direction to policy and funding initiatives, any vision about the provision of effective care for childbearing women and children needs to address the broader issues of gender equity, women's empowerment and community acceptance, quality maternity care (Bowser and Hill, 2010), and respect for and valuing of midwives (Brodie, 2013). This involves placing gender equity at central stage (United Nations, 2000).

The future provision of effective care for childbearing women and newborns also needs to consider the changing demographics in different social contexts. This may include fewer people residing in remote settings, lower fertility rates, an ageing population and more technological opportunities for providing maternity care and organizing maternity workers, and their associated potential for increasing costs. Despite urbanization, the needs of women in rural and remote areas remain important, as are those of women living in urban areas (urban poor) who may not have access to services, for financial or other reasons.

Finally, the MDGs have helped focus political attention on the need to improve maternal health because of the dedicated MDG 5 to improve maternal health. The proposed policy context of universal healthcare coverage is in principle highly commendable. But it is less straightforward than targets to reduce mortality rates and could even be regressive, if political support and public funding are diverted from maternity care to more general healthcare. Hence, universal healthcare coverage strategies also need our central consideration.

The WHO defines universal healthcare coverage as the goal that all people can obtain the prevention and treatment health services they need without suffering financial hardship when paying for them (WHO, 2010). For a community or country to achieve universal health coverage, several factors must be in place, including:

- a strong, efficient, well-run health system that meets primary healthcare needs for all residents, including the most vulnerable – services range from care of individuals with human immunodeficiency virus (HIV) and other sexually-transmitted infections (STIs), tuberculosis, malaria and other non-communicable diseases, as well as maternal and child health;
- affordability – a system for financing health services so people do not suffer financial hardship when using them;
- access to essential medicines and technologies to diagnose and treat medical problems; and
- sufficient capacity of well-educated, motivated health workers and educators to provide services to meet community needs, based on the best available evidence.

Universal access to reproductive, maternal and child health services must thus be a major priority for the next decade, as should strategies and models that use a limited health workforce wisely (WHO, 2010). According to Quick and colleagues,

> [w]omen, children, and others most visibly affected by health care inequalities stand to gain the most from well-designed UHC programs… UHC removes financial barriers such as user fees at the point of service, reducing burdens on poor people, and especially women, who often have primary responsibility for their families' health care but lesser access to cash. (Quick et al., 2014: 2)

The ‘Partnership for Maternal Newborn and Child Health’ (PMNCH, 2011) identified the essential interventions for maternal, newborn and child health. Furthermore, ‘The State of the World’s Midwifery Report’ *(*SoWM*)* (UNFPA, 2011) highlighted the challenges that exist within many well-resourced and low-to-middle income countries in retaining an effective midwifery workforce in the 58 lowest resource countries (Crowe et al., 2012).

Yet despite the global calls for governments to act to make motherhood safer and healthy for all childbearing women that began in 1985, and the more recent calls for universal healthcare coverage, effective midwifery workforces and equitable maternal health, the last few decades have seen fiscal policies of cost containment, coupled with market-focused policies stressing individual responsibility and reliance on market forces in many countries, even in well-resourced nations with long traditions of universal healthcare coverage. At the same time, several low-to-middle income countries have been working towards universal access to health services, especially for poor and excluded populations, whist at the same time liberalizing the market for healthcare provision for their growing middle-classes (see Chapter 10 by Sen and Iyer, and Chapter 13 by Giovanella and Faria).

Researchers have not paid enough attention to these contradictory developments and the impact of changing roles of the state versus the market in maternity care provision within and across countries. We take up this challenge below, recognizing that even when privatization is not occurring, maternity care is subjected to market-minded efficiency measures that may create new barriers for equitable maternity care and also lower the quality of care.

## Maternity care in low- to middle- and high-resourced countries: case studies

Our four case studies – Nepal, Chile, Canada and England – cover low- to middle- and high-resourced countries and an array of healthcare systems. These cases serve to highlight two key dimensions: (1) the global challenge of contemporary market-driven social policy for health equity and women's right to quality maternity care, and (2) the diverse and context-specific effects for maternal and child health, the health workforce, and healthcare provision. Table 6.1 below provides information on selected indicators of demographic and maternal health in the four case examples.

Table 6.1 Key demographic and maternal health factors for four case studies, 2011

| | GDP per capita (current USD, rounded) | Health expenditure per capita (current USD) | Labour participation rate, female (% female population ages 15+) | Life expectancy at birth, female (years) | Mortality rate, adult, female (per 1,000 female adults) |
|---|---|---|---|---|---|
| Nepal | 704 | 33 | 57.2 | 68.7 | 164.03 |
| Chile | 14,513 | 1,075 | 54.5 | 82.3 | 58.79 |
| Canada | 51,554 | 5,630 | 74.1 | 83.3 | negligible |
| UK | 39,503 | 3,609 | 69.5 | 82.7 | negligible |

*Source:* World Bank, 2014

### *Nepal*

Nepal is by far the poorest country of all our four focus countries (Table 6.1). It has seen major social and political changes over the past three to four decades, moving from being a repressive Hindu Kingdom (the only one in the world) to a Parliamentary Democracy with neoliberal policies. The past three decades have seen the liberalization of society, including the media, health services and education. To compete with the monopoly of state radio and television, Nepal experienced the introduction of commercially-based newspapers, television, FM radio and internet providers. There has also been an exponential growth of private colleges offering

medicine and health-related courses: from one medical school in the government university in 1990 to 15 in 2009, and from five nursing colleges in 1990 to over 50 today.

Nepal is seen as one of the success stories in MDG 5 improvement with MMR declining from 770 per 100,000 births in 1990 to 170 in 2010, a decrease of 78 percent (WHO, 2013). The country has seen several key policies that support MMR reduction. First, it had long been realized that illegal and high-risk abortions are an important contributor to the high MMR (Engel et al., 2013). Abortion was finally legalized in Nepal in 2004, and the first government abortion services started two years later in the capital Kathmandu (Thapa, 2004). Abortion services are now available in different parts of the country, which helped to reduce the number of illegal and high-risk abortions and lowered the MMR.

Supported by the UK government though the Department for International Development (DfID), Nepal started paying women an incentive to attend antenatal services and deliver in a health institution in 2009. The government also initiated free delivery services and paid pregnant women an incentive to attend recognized maternity units: USD5.80 in the flat plains in the South, USD11.50 to women in the hills in the centre of the country, and USD17.30 to those living in the mountains. In addition, pregnant women receive about USD5 if they attend least four antenatal check-ups, as recommended by the WHO.

Furthermore, especially given it is a low-income country, contraceptive use is reasonably high in Nepal, with about half of all women in the 2011 DHS survey reported using contraception. This proportion is slightly lower that the global average contraceptive use in low-income countries of 62 percent (United Nations, Department of Economic and Social Affairs, 2010). One of the country's key sources of income is remittances, with millions of Nepali (mainly men) working abroad and sending money home (Engel et al., 2013). Over half of all households receive

remittances, which has two effects: first, some poverty reduction over the past 15 years; and second, with men working abroad, often being away for over two years at a time, fewer pregnancies for Nepali women of childbearing age.

As result of the above factors and related to the general development of the country, the total fertility rate for Nepal has dropped significantly. In the 1980s, the average Nepali woman had about six children; in 2011 the total fertility rate had decreased to 2.6 (Engel et al., 2013). Having fewer children means less chance of complications during childbirth in higher order pregnancies and wider spacing of pregnancies, and in Nepal it often also means having the first child slightly later. Yet the recent MMR reduction in Nepal is associated with two paradoxes. First, midwifery is not recognized as an autonomous profession (Bogren et al., 2013); currently midwifery remains a specialty of nursing. Second, universal access to reproductive health as measured by having a skilled attendant at birth is still very low.

The first and foremost barrier to improving maternity care is the vulnerable position of women in what still remains a highly patriarchal society. At the beginning of the new millennium (2001), the female Nepali literacy was just over one third (35%); in 2010, the rate had nearly doubled (57%). While this progress is to be laude, nearly half of the female population remains illiterate. Many young pregnant women are not always in a position to make decisions about the reproductive healthcare/maternity care they need (Simkhada et al., 2010).

Nepal also lacks appropriate civil registration (especially birth registration in remote areas), which means it is simply not known how many babies were born and died shortly after birth as they were never registered. In terms of maternity care funding, a large portion of national healthcare expenditure is from aid donors, both international organizations such as the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF), foreign

governments such as USAID, or international non-governmental organizations such as ‘Safe the Children’. It is a worrying situation for any country when aid makes up a large proportion of the expenditure; in Nepal some 40 to 45 percent of all public health expenditure depends on foreign funding (Engel et al., 2013).

Despite its progress in, for example, reducing maternal mortality, total fertility and increasing the number of girls attending school, Nepal has a long way to go before it can claim to offer universal access to maternity care, let alone healthcare more generally. There is a lack of skilled attendants who can attend deliveries safely. Recognizing midwifery as an autonomous profession would help a little, but training midwives and creating posts for them is a long-term solution which might not be sustainable in a country which is so dependent on foreign aid. Meanwhile, caesarean-section rates in Nepal are rising in the group of urban middle-class educated women.

### *Chile*

Healthcare financing mechanisms come increasingly under the spotlight around the world with the global push for universal healthcare, and it is important to take account of experiences with different approaches. Despite some compelling arguments for the equity benefits of single national risk pools, neoliberal ideology at its purest tends to underpin a view that private health insurance schemes for the expanding ‘new middle classes’ is the way forward to keep government sector costs under control. Such an approach promises profitable new opportunities for the transnational insurance industry.

Chile was an early adopter of private insurance schemes (see Chapter 13 by Giovanella and Faria), and its trajectory in the maternity care sector during the 1980s and 1990s offers an example of how such government policy on healthcare financing, combined with a policy of

actively encouraging private sector involvement, can produce unforeseen distortions in service delivery that become difficult to reverse.

Chile today has a literate, urbanized population of 17 million, and a rapidly expanding economy, such that it has recently been re-classified by the World Bank (2014) from a 'middle income' to a 'high income' country (Table 6.1). Chile also has a long history of social welfare policy, including a national health service established in 1952. Chile currently boasts the second lowest MMR in the American continent after Canada. This decreased from 270.7 per 100,000 live births in 1957 to 18.2 per 100,000 by 2007 (Koch et al., 2012) and has been maintained at that level since (MINSAL, 2011). The maternal mortality decline reflects improvements in women's education, their nutrition and control of their fertility, universal coverage with skilled attendance at delivery, and a strong public health role for midwives (*matronas*) who provide pregnancy, normal delivery and postpartum care in the government sector, breast feeding support, family planning and cervical screening services.

But beyond the impressive mortality statistics the picture over the last few decades has been less equitable. Chile's well-established public sector services were badly affected by monetarist policies applied during the period of Pinochet military dictatorship (1973–89). Public spending was severely reduced in this period and decentralization broke up the administration of a unified healthcare system. Both of these impacted on the quality of care provided in the public sector facilities. The parallel promotion of private health insurance by Pinochet's government in the 1980-90s resulted in a mushrooming of private sector healthcare facilities, including maternity hospitals and smaller bedded 'clinics'. At its peak, about a third of pregnant women were receiving their maternity care in the private sector (Murray and Elston, 2005).

From 2000 onwards there have been attempts to reverse this trend and to renew emphasis on legal entitlement to high quality healthcare within a rapidly re-expanding public sector (Sandall et al., 2009). But the segmented financing structure introduced during the previous decades, and the prominent role it gives to private insurance companies, private healthcare facilities and private practice by medical specialists, still remains. So far the policy has primarily been to modify its effects so that access to care for an expanding number of specified medical conditions is available to all by 'leveraging' private sector provision to supplement what can be offered by government hospitals. All health insurance schemes, the National Health Fund and the private plans, must now guarantee this 'evidence-based' care within a pre-determined time period under the *Acceso Universal con Garantías Explícitas* (or Plan AUGE).

Maternity care is free only to 'indigents' in Chile. Most women's pregnancy care costs have to be paid for with a combination of out-of-pocket payments and reimbursement from the insurance policies to which all salaried workers subscribe – either the National Health Fund or one of the private plans. This system provides the basic social protection which undoubtedly contributes to the low rates of maternal mortality, but it does little to counteract Chile's wide socio-economic inequalities. While all women have access to some type of maternity care, those with greater personal economic resources receive far more personalized care in much pleasanter surroundings of their choice.

Detailed mixed-methods research has also shown how the funding mechanisms in such situations distorted clinical decision-making (Murray and Elston, 2005). The promotion of private health insurance in the 1980s-1990s, and concomitant rise in private practice by obstetricians, in turn led to a spectacular rise in caesarean section rates. On the one hand, the private insurance schemes failed to recognize midwives as lead practitioners, relegating them to a subordinate role as obstetrician's personal employee in the private sector. On the other,

obstetricians who now had work commitments both in the public sector hospitals and in the many private sector facilities found they needed to programme their private clients' births to ensure that they could personally attend to them. Families for their part accepted these arrangements as they wished to avoid being saddled with extra charges associated with 'unsocial hours' care.

Labour and delivery care became increasingly interventionist, and for the middle classes in Chile caesarean section became 'normalised'. By 2010, caesarean section rates in the private sector had reached 66 percent, and in the public sector 37 percent (Guzmán, 2012). Neither the Ministry of Health nor the insurance companies or their regulator have found this an easy issue to tackle. In the public sector, strategies such as 'second opinion' policies have been employed and projects have piloted introduction of a more holistic and less interventionist approach to labour and delivery care in hospital. But the main problem resides in the private sector, and the commonly used diagnosis of 'distocia' (prolonged labour) has been, in retrospect, difficult to contest.

Chile has many accomplishments in the maternal health field. Coverage by skilled attendant is universal, financial access to public sector care is assured, midwives are well-trained, and maternity care practice is well-regulated. However, Chile's experience has important lessons about design of health insurance, the consequences of segmentation and fragmentation of services, and reliance on market forces that other countries would do well to heed.

### *Canada*

Costs of maternity services in Canada, including salaries for service providers, are paid for through general taxes and included as public services under the country's universal healthcare programme, Medicare, established in the early 1970s. As noted above in the Chilean case,

Canada does not allow parallel private healthcare. Virtually all pregnant women in Canada give birth in hospitals and receive maternity care from obstetricians or family physicians, although professional midwives have emerged as autonomous providers since the mid-1990s (more on this below). While attractive in regard to universal coverage, the Canadian healthcare system is costly (Table 6.1) and has other shortcomings, as outlined below.

Similar to many other countries, neoliberal reforms in recent decades aimed at keeping healthcare costs under check have had contradictory results. Caesarean section rates have steadily increased, with total national caesarean sections increasing from 17.6 percent in 1995, to 21.1 percent in 2000 and 27.1 percent in 2011. The variation in caesarean section rates is almost double across the provinces/territories. In 2011, in British Columbia the rate was 32.0 percent, while Saskatchewan (23.1%) and Manitoba (21.4%) had among the lowest rate (CIHI, 2013). Furthermore, while the caesarean section rate for mothers age 40 or older is currently double (42%) the rate for mothers age 20 to 24 (21%), there is little evidence that this variation is based on mothers' demand – the so called 'too posh to push' argument (Bourgeault et al., 2008).

On the positive side, publicly funded midwifery services have become available for care throughout pregnancy, birth and post-birth. After considerable public debate and advocacy by consumer organizations, in the mid-1990s midwifery became institutionalized and publicly-funded initially in the province of Ontario, with British Columbia following soon thereafter. Today, the midwifery option is available in seven regions in roughly half of the provinces in Canada (Bourgeault et al., 2004).

Midwives hold a university bachelor's degree through one of the newly-established direct-entry (non-nursing prerequisite) programmes and are certified by the provincial/territorial Colleges of

Midwives to work as a primary care provider during pregnancy, labour and delivery, and the immediate post-partum period. Midwives, who work independent of nursing and medicine, are thus now a viable service provider for pregnant women in some regions, reimbursed through the public purse. Aboriginal midwifery services have also become a publicly-funded option in a small number of communities.

Yet the impact of this midwifery expansion to date has been small. In fact, less than five percent of births in Canada are currently attended by a midwife because the growth of the profession has been slow. While the percentage is higher in some provinces, a substantial proportion of women in all parts of the country who want to see a midwife are currently unable to find one. Women with lower education, younger mothers, women without a partner, Indigenous women, and women living in rural and remote areas or socioeconomically disadvantaged communities are especially disadvantaged (National Aboriginal Health Organization, 2004). Privately-delivered midwifery and doula services have emerged to fill this care gap but such services tend to be quite expensive and thus available to families with disposable income to pay for these services.

In sum, despite having universal medical coverage nationwide, the provision of maternity care in Canada remains stratified by geographical location, social status factors, and capacity to pay for services on the market for midwives and doulas in regions where their services are not covered under provincial or territorial health plans (Benoit et al., 2012), leaving less-advantaged pregnant women and their families with two main alternatives: to rely on their own resources for care provision, or to rely on the market for the purchase of care services. For these conditions to change for the positive, there is an urgent need for policy-makers to invest in the formal education of midwives, as promised by the current Quebec government, for increased

opportunities for Aboriginal midwives to be receive culturally-appropriate training options, and for public funding of midwifery services in all regions of the country.

### *England*

In common with several other well-resourced country health systems, including Canada, England has been experimenting with market reforms for the last three decades. One consequence is that the Health Minister's duty to provide a comprehensive health service, as laid out in 1946, is now under threat. The Government's 2010 White Paper, *Equity and Excellence: Liberating the NHS* (Department of Health, 2010) and subsequent Health and Social Care Bill 2011 herald the most controversial proposals in the history of the National Health Service (NHS) in England. Private healthcare has existed in parallel with the NHS since its inception, but the current intention is to replace the English NHS with a commercial market in which potential suppliers of health care and patients will compete for NHS funds from commissioning consortiums. It is noteworthy that we focus here on the NHS in England whereas just a few years ago we would have referred to the NHS in the United Kingdom (UK). The political changes towards a more neoliberal market within the NHS are most profound in England, whereas governments in Wales and Scotland are trying to maintain more of the spirit of the original NHS (Bevan et al., 2014).

The effect will be to overturn the basic principle of the NHS whereby health services to the whole geographic population are largely publicly administered with provision largely under public ownership and control. The proposals promise a commercial system in which the NHS is reduced to the role of government payer. The latest re-organization of the NHS is the largest in history and still continues.

Having a baby is the most common reason for admission to hospital in England. In 2012, there were nearly 700,000 live births, a number that has risen by almost a quarter in the last decade. Contrary to the current situation in Canada, midwives in England attend all women in labour, and are the senior professional at all vaginal births. There has also been an increase in the proportion of 'complex' births, such as multiple births or those involving women over 40. Maternity care cost the NHS around USD4.3 billion in 2012 to 2013. The Department of Health is ultimately responsible for securing value for money for this spending. Since April 2013, maternity services have been commissioned by clinical groups overseen by NHS England. This agency assigns maternity service delivery to NHS trusts and NHS foundation trusts. These include obstetric units, and associated community-based services, such as midwife-led units and community midwifery services.

The House of Commons Public Accounts Committee report on maternity services in England was brought together evidence from stakeholders who reported that they were confused as to the current policy objectives and whether 'maternity matters' removed the policy framework (Accounts, 2014). In addition, some of the Department's main objectives for maternity services, such as continuity of care for women by midwives, are described only as aspirations not objectives. The Department and NHS England struggles to articulate who is accountable for even the most fundamental areas of maternity care, such as ensuring the NHS has enough midwives. At the local level, it is unclear how commissioners are ensuring maternity services meet the Department's policy objectives, or how they are holding trusts to account. Over a quarter of trusts lacked a simple written service specification with their commissioner last year.

There is evidence from stakeholders that many maternity services are running at a loss, or at best breaking even, and that the available funding may be insufficient for trusts to employ enough midwives and consultants to provide high quality, safe care. The Department has

recently introduced a new payment framework for maternity care in order to have greater leverage on efficiencies. However, the evidence received suggests that the Department had only limited assurance that the new tariff payments would provide sufficient income to providers to deliver the Department's objectives. Policy and commissioning stakeholders believed more could be delivered for less money with better outcomes if there were more midwife-led birth centres available. The payment framework was one factor inhibiting the increase in such birth centres.

According to the Royal Colleges and the House of Commons Public Accounts Committee report, there is currently a shortage of midwives and obstetricians in England, and evidence suggests quality of care is of poorer on weekends. The clinical negligence bill for maternity services is considered to be unreasonably high, with nearly a fifth of spending on maternity services consumed by the NHS scheme for clinical negligence cover. Clearly victims of poor care need to be properly overseen, but clinical negligence costs have spiralled and reduce the money available for frontline care (Accounts, 2014).

Maternity cases account for a third of total clinical negligence payments and the number of maternity claims has risen by 80 percent over the last five years. The rate of babies who are stillborn or die within seven days of birth in England compares poorly with the other UK nations and some European countries, although the reasons for this are unclear. Some USD796 million, nearly a fifth of trusts' spending on maternity services, is for clinical negligence cover, equivalent to USD1160 per birth (Accounts, 2014). At the same time, caesarean section rates have continued to climb. Although not as high as Chile or Canada, the caesarean section rate for the England and the other UK countries was 24.1 percent in 2011 (http://www.oecd-ilibrary.org/statistics).

The neoliberal mantra of English politicians has for two decades been that all patients should have more choice – specifically, choice in place of birth and type of care. Research by the National Federation of Women's Institutes (NFWI) and the National Childbirth Trust (NCT) indicates that women want more choice about where to give birth, and most do not want to give birth in a hospital obstetric unit, with care led by consultants. While the number of midwifery-led units, where midwives take primary responsibility for care, increased from 87 in 2007 to 152 in 2013, but only eleven percent of women gave birth in these units in 2012, the remainder of women still gave birth in a location *not* of their choosing (NFWI-NCT, 2013).

A policy focus on choice has had the most negative impact on vulnerable women, who are less able to exercise such choice. The NHS has had a specific objective to promote public health with a focus on reducing inequalities in maternity care since 2007. However, the latest available data (from 2010) on women's experiences showed Black and minority ethnic mothers were less positive about the care they received during labour and birth than White mothers. Black and minority ethnic mothers were also significantly more likely to report shortfalls in choice and continuity of care (Quality Care Commission, 2014) . Maternity policy in England for the last two decades has been progressive in vision, with a commitment to NHS provision for 99 percent of the population. However, it has suffered from lack of attention in implementation, and a complacency regarding quality and safety of care, the costs of which have been recently highlighted above.

## Conclusion

Maternity care provides a lens through which to examine the impact of broader healthcare policy initiatives in less-resourced and well-resourced countries around the world today. Despite recent calls to address the broader issues of gender equity, women's empowerment and community

acceptance, quality maternity care and respect for and valuing of midwives, our overview of developments in four case examples indicates that much remains to be done to make this a reality (see also Sandall et al., 2012).

Commodification and marketization trends disrupt the social-democratic approach to maternity care, tend to remove the focus from equal access and equity to efficiency, purported customer-centredness, and does little to help cost containment in the long-run. The outcome of these neoliberal reforms is often in conflict with the purported social-democratic ethos of global health policy. These reforms also run contrary to MDG 5 to improve maternal health.

The political attractiveness of market approaches is their claim to provision of more choices for maternity care consumers (to use the marketing term). The corollary to more choices is fragmentation of services, increased barriers to access and lack of oversight that can arise in a market system – all characteristics of the largest market-based system in well-resourced economies, namely the United States (Declercq and Simmes, 1997). A more fragmented structure for services in those countries were there have been unitary access, such as Chile and Canada, are also appearing with consequences for access (see also, for India, Chapter 10 by Sen and Iyer).

**Summary**

- Despite the global attention which begun in 1985 to make motherhood safer and healthy for all women, of all eight MDG goals, least progress has been reached with MDG 5 relating to maternal health. In both well-resourced and less-resourced countries, midwifery training is inadequate, access to midwifery services lacking, especially for vulnerable women, and caesarean sections abnormally high.

- While maternal mortality ratios have dropped, universal access to reproductive health is being reduced in some well-resourced countries and remains an elusive goal in many less-resourced countries.
- The last few decades have at the same time witnessed neoliberal fiscal policies than have resulted in the commercialization and privatization of some maternity services.
- Commodification and marketization runs contrary to the social-democratic approach to maternity care; an additional negative outcome is increased medicalization of maternity care and reduced role for midwives as pivotal maternal healthcare providers.

## Key reading

Benoit, C., M. Zadoroznyj, H. Hallgrimsdottir, A. Treloar and K. Taylor (2010) 'Medical Dominance and Neoliberalisation in Maternal Care Provision,' *Social Science & Medicine,* 71 (3), 475–81.

Quick, J., J. Jay and A. Langer (2014) 'Improving Women's Health through Universal Health Coverage,' *PLoS Medicine*, 11: e1001580.

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## References

Accounts – House of Commons Committee of Public Accounts (2014) *Maternity Services in England* (London: The Stationery Office Limited).

Benoit, C., C. Stengel, R. Phillips, M. Zadoroznyj and S. Berry (2012) 'Privatization and Marketization of Post-birth Care,' *International Journal for Equity in Health,* 11 (1), 61.

Benoit, C., M. Zadoroznyj, H. Hallgrimsdottir, A. Treloar and K. Taylor (2010) 'Medical Dominance and Neoliberalisation in Maternal Care Provision,' *Social Science & Medicine,* 71 (3), 475–81.

Bevan, G., M. Karanikolos, J. Exley, E. Nolte, S. Connolly and N. Mays (2014) *The Four Health Systems of the United Kingdom: How Do They Compare?* (London: Nuffield Trust).

Bogren, M., E. van Teijlingen and M. Berg (2013) 'Where Midwives Are Not Yet Recognised: A Feasibility Study of Professional Midwives in Nepal', *Midwifery,* 29 (10), 1103–9.

Bourgeault, I., C. Benoit and R. Davis-Floyd (eds.) (2004) *Reconceiving Midwifery* (Montreal-Kingston: McGill-Queen's University Press).

Bourgeault, I., E. Declercq, J. Sandall, S. Wrede, M. Vanstone, E. van Teijlingen, R. De Vries and C. Benoit (2008) 'Too Posh To Push! Comparative Perspectives on Consumerism in Maternity Care: Maternal Request Caesarean Sections in Canada, the U.S., the U.K. and Finland', *Advances in Medical Sociology*, 10, 99–23.

Bowser, D. and H. Hill (2010) *Exploring Evidence for Disrespect and Abuse in Facility-based Childbirth*, USAID TRAction Project (Boston: Harvard School of Public Health).

Brodie, P. (2013) 'Midwifing the Midwives: Addressing the Empowerment, Safety of, and Respect for, the World's Midwives,' *Midwifery,* 29, 1075–6.

Care Quality Commission (2014) *National Findings from the 2013 Survey of Women's Experiences of Maternity Care* (London: Care Quality Commission).

CIHI (2013) *Highlights of 2011–2012 Selected Indicators Describing the Birthing Process in Canada* (Ottawa: CIHI).

Crowe, S., M. Utley, A. Costello and C. Pagel (2012) 'How Many Births in Sub-Saharan Africa and South Asia Will Not Be Attended by a Skilled Birth Attendant between 2011 and 2015', *BMC Pregnancy and Childbirth,* 12: 4.

Declercq, E. and D. Simmes (1997) 'The Politics of "Drive-through Deliveries', *Milbank Quarterly,* 75 (2), 172–202.

Department of Health (2010) *White Paper, Equity and Excellence: Liberating the NHS* (London: Department of Health).

Engel, J., J. Glennie, S. R. Adhikari, S. W. Bhattarai, D. P. Prasai and F. Samuels (2013) *Nepal's Story: Understanding Improvements in Maternal Health* (London: Overseas Development Institute).

Graham, W. J., A. McCaw-Bills and S. Munjanja (2013) 'Translating Coverage Gains into Health Gains for All Women and Children: The Quality Care Opportunity', *PLoS Medicine*, 10: e1001368.

Guzmán, E. (2012) 'Perfil epidemiológico de la cesárea en Chile en la década 2000-2010', *Medwave,* 12: e5331.

Koch, E., J. Thorp, M. Bravo, S. Gatica and C. X. Romero (2012) 'Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007', *PLoS one,* 7: e36613.

MINSAL (2011) *Defunciones y Mortalidad Materna, según región. Chile 2000-2010,* at: http://deis.minsal.cl/vitales/vitales2010/Mortalidad_Materna/Defunciones_Mortalidad_Materna_region_2000_2010.htm, accessed 5 May 2014.

Murray, S. F. and M. A. Elston (2005) 'The Promotion of Private Health Insurance and its Implications for the Social Organisation of Healthcare', *Sociology of Health and Illness,* 27, 701–21.

National Aboriginal Health Organization (2004) *Midwifery and Aboriginal Midwifery in Canada* (Ottawa: NAHO).

NFWI-NCT – National Federation of Women's Institutes and NCT (2013) *'Support Overdue': Women's Experiences of Maternity Services*, at:

http://www.thewi.org.uk/__data/assets/pdf_file/0006/49857/support-overdue-final-15-may-2013.pdf, accessed 5 May 2014.

PMNCH – Partnership for Maternal, Newborn and Child Health (2011) *A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health* (Geneva: PMNCH).

PMNCH – Partnership for Maternal, Newborn and Child Health (2014) *Every Newborn,* at: http://www.everynewborn.org/, accessed 25 January 2014.

Quick, J., J. Jay and A. Langer (2014) 'Improving Women's Health through Universal Health Coverage,' *PLoS Medicine*, 11: e1001580.

Sandall, J., C. Benoit, E. van Teijlingen, S. Wrede, R. Westfall and S. Murray (2009) 'Social Service Professional or Market Expert? Maternity Care Relations under Neoliberal Healthcare Reform,' *Current Sociology,* 57 (4), 529–53.

Sandall, J., C. Benoit, E. van Teijlingen, S. Wrede, E. Declerq and R. De Vries (2012) 'Gender and Maternal Healthcare', in E. Kuhlmann and E. Annandale (eds.), *The Palgrave Handbook of Gender and Healthcare* (Basingstoke: Palgrave), 389–404.

Simkhada, B., M. Porter and E. van Teijlingen (2010) 'The Role of Mothers-in-law in Antenatal Care Decision-making in Nepal: A Qualitative Study,' *BMC Pregnancy & Childbirth,* 10: 34.

Thapa, S. (2004) 'Abortion Law in Nepal: The Road to Reform,' *Reproductive Health Matters,* 12, 85–94.

United Nations (2000) *United Nations Millennium Declaration,* Resolution Adopted by the General Assembly, at: http://www.un.org/millennium/declaration/ares552e.htm, accessed 5 May 2014.

United Nations (2010) *About Every Woman Every Child: An Unprecedented Global Effort to Save Lives*, at: http://www.un.org/millenniumgoals/pdf/EveryWomanEveryChild.pdf, accessed 26 April 2014.

United Nations (2012) *The Millennium Development Goals Report 2012* (New York: United Nations).

United Nations, Department of Economic and Social Affairs (2010) *The World's Women 2010. Trends and Statistics,* ST/ESA/STAT/SER.K/19 (New York: United Nations).

UNFPA – United Nations Population Fund (2011) *The State of the World's Midwifery Report* (New York: United Nations Population Fund).

Van Teijlingen, E., V. Hundley, Z. Matthews, G. Lewis, W. J. Graham, J. Campbell, P. Ten Hoope-Bender, Z. A. Sheppard and L. Hulton (2014) 'Millennium Development Goals: All Good Things Must Come to an End, so What Next?' *Midwifery,* 30, 1–2.

WHO – World Health Organization (2010) *The World Health Report. Health Systems Financing: The Path to Universal Coverage* (Geneva: WHO).

WHO – World Health Organization (2013) *World Health Statistics 2013* (Geneva: WHO).

World Bank (2014) *World Development Index* (Washington, DC: World Bank).