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Understanding the social organisation of maternity care systems: midwifery as a touchstone

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Abstract Theories of professions and healthcare organisation have difficulty in explaining variation in the organisation of maternity services across developed welfare states. Four countries – the United Kingdom, Finland, the Netherlands and Canada – serve as our case examples. While sharing several features, including political and economic systems, publicly-funded universal healthcare and favourable health outcomes, these countries nevertheless have distinct maternity care systems. We use the profession of midwifery, found in all four countries, as a 'touchstone' for exploring the sources of this diversity. Our analysis focuses on three key dimensions: (1) welfare state approaches to legalising midwifery and negotiating the role of the midwife in the division of labour; (2) professional boundaries in the maternity care domain; and (3) consumer mobilisation in support of midwifery and around maternity issues.

Keywords: cross-national comparison, maternity care system, midwifery, welfare state, inter-professional interests, citizen's relations, service users

Introduction

Healthcare systems reflect a complex mix of societal norms, cultural values, government regulations, formal institutional policies and informal practices, tensions over professional boundaries, and social actions of patients and their

advocates. These cross-cutting influences present a challenge to those who study healthcare arrangements and design policies to make healthcare more effective and efficient. This paper advances our understanding by examining the provision of maternity care in four high-income countries: the United Kingdom (UK), Finland, the Netherlands and Canada. All have economies based largely on the free market, social-democratic political systems, and impressively low maternal and infant mortality rates. In addition, all devote substantial public resources to healthcare services and include midwives as providers[1]. Yet these same countries exhibit marked variation in the social organisation of maternity care.

It is true that these four countries have notably different welfare regimes: Canada and the UK are liberal welfare states, Finland is a Nordic universalist welfare state in the social democratic tradition, and the Netherlands is an example of a conservative welfare state of Continental Europe (Esping-Andersen 1990). But, as shown below, these macro-level differences do not fully explain the diversity in maternity care systems.

In our analysis we use midwifery, a female-dominated occupation serving an exclusively female clientele, as a *touchstone*[2] for explaining this variation. The social location of midwifery reveals a society's fundamental cultural ideas about women as (1) autonomous (or not) professionals in the maternity division of labour and as (2) legitimate (or not) recipients of midwifery care services across the childbearing period.

A sociological analysis of midwifery helps us to advance thinking about the organisation of maternity care systems beyond what social or health policy perspectives would allow. It also helps us to better understand the operation of jurisdictional claims in maternity care and the way governments, professionals and clients shape maternity care systems. Our analysis uses a 'decentred approach' to comparative research as developed in *Birth by Design* (De Vries *et al*. 2001). The interdisciplinary team for that project included researchers with 'local knowledge' of the social organisation of maternity care in several Western European and North American countries. One of the crucial reasons for assembling such a team was to move the analysis beyond studies by one or two researchers focused on explaining events in one country by contrasting it to a second or sometimes third case example (Benoit and Heitlinger 1998). Our aim was to 'decentre' the study of maternity care from particular national contexts and to move the analysis to a level where any and all contexts were worthy of sustained examination. Having decentred social contexts, researchers also became uncoupled from their disciplines and particular perspectives and came to share a less ethnocentric and more theoretically sophisticated understanding of healthcare regimes.

A comparative theoretical framework for the study of maternity care

Our framework rests on concepts drawn from three areas of study: comparative welfare states, the sociology of professions and contemporary social movements.

We also observe how the gendered composition of groups influences the web of inter-relations between the state, professions and birthing women. We draw attention to differences in the macro, meso and micro organisation of heath care systems across time and place, differences that originate in conflict and negotiation among actors in the maternity care domain (Allen 1997).

Welfare state theory

Welfare state theory defines postwar welfare capitalism as a 'commitment of some sort which modifies the play of market forces in an effort to realise greater social equality for its population' (Ruggie 1984: 11). Feminist scholarship has demonstrated that different welfare regimes have divergent consequences for women. The Nordic states are often called 'women-friendly' because their universalistic system provides women direct access to services as citizens and because social policy there is aimed at both gender and class equality. Women's social rights in conservative welfare states are often defined in terms of their place in the family with the assumption of the male as breadwinner. In liberal welfare states, the state is said rarely to act in favour of women's gendered interests (Lewis 1992).

A central debate among theorists is whether or not the post-industrial, globalised era has created an irreversible decline in developed welfare states, effacing once clear differences in public funding, national regulations and formal policies (Coburn 2001). If this is indeed the case, then maternity care systems in our four case examples should likewise have become more alike over time, with more services being delivered in the private sector, reduced public outlay for maternity services and policies less favourable to women. Others argue that developed welfare states, even during this period of global capitalism, have maintained their distinctiveness in several areas, including the organisation of healthcare (Korpi 2003).

Both the convergence and divergence arguments find support in the development of maternity care systems, depending on the organisational level studied. There has been a growing convergence towards the rationalisation of the maternity division of labour across many welfare regimes; some have emphasised midwife care as a low-tech and therefore low-cost measure. In other cases, rationalisation is sought through the centralisation of births in large hospitals. In order to understand the persisting diversity of maternity care systems, it is necessary to pay attention to the nature of the state and its interests in shaping maternity care in particular ways that may be more (or less) friendly to women workers and recipients of care (Davies 2003).

Sociology of the professions

The sociology of professions draws attention to the unequal relationships among occupational groups within the division of labour and the ensuing struggle over license and mandate. Central to our topic is the power of the medical profession to subordinate midwifery, to limit its work to peripheral tasks and in some instances to ban it from legal practice (Willis 1989, Bourgeault *et al.* 2004). This understanding of professional relationships draws,

implicitly or explicitly, on the neo-Weberian concept of social closure and patriarchy (Abbott 1988, Witz 1992). This (male) power-centric view of the professions has been challenged by some who argue that professional boundaries are sometimes successfully contested, though not always in the manner that allied professionals themselves hoped for (Allen 1997, 2000). Thus, the power of medicine is not all-supreme over midwives' day-to-day work (Lay 2000).

Consumer interests

The final element in our framework is consideration of consumer impact on maternity care policy. The literature on consumer groups describes the role of activists and ordinary women in pressuring for change in the organisation of maternity systems. Study of the dynamics of collective challenges to policy and practice requires sensitivity to the institutional context of policymaking and service provision (Bourgeault, DeClercq and Sandall 2001). Our case studies show how social movements are socially-situated and vary in intensity and impact on maternity care systems and the position of midwives.

Cross-national comparison of maternity care systems

United Kingdom

At different points, a welfare-centred approach has dictated the organisation of maternity care services in the UK, either in consort with, or against the interests of the medical profession. Moreover, the maternity care arrangements across the historical period point to both the gendered and interactive nature of the maternity care domain.

In the UK, pronatalist 'politics of motherhood' resulted in the creation of social and health programmes for mothers early in the 20th century, though midwives initially had to fight hard to be included in state provision. By the 1930s, two models of care were predominant, a consultant-based hospital system and a community-based maternal and child health system. The 1936 *Midwives Act* and the National Maternity Service was seen as part of the solution to high levels of maternal mortality. The goal was to provide a national salaried community-based midwifery service, including antenatal and postnatal care, home birth and general practitioner (GP) back up.

The creation of the National Health Service (NHS) in 1948 gave women access to free maternity care for the first time and strengthened consultant-based hospital services. By the 1970s, public pressure for hospital-based services had grown, GPs had taken over the provision of care from municipal midwife-run clinics, and obstetricians became increasingly involved in 'normal' childbirth; in 1970 the government recommended hospitalisation for all births (DHSS 1970). Although midwives continued to be the primary attendant at the majority of hospital births, their role became fragmented as a result of new technologies and limits on jurisdiction and scope of practice. Thus, we see change from state support for autonomous midwives to medical dominance over their mandate and practice.

The main consumer organisations concerned with maternity care – the National Childbirth Trust, Association for Improvements in Maternity Care, and Maternity Alliance – began to challenge such medical dominance. In the 1980s research evidence also began to play an important role in legitimising these concerns, resulting in an alliance between consumers, the Royal College of Midwives (RCM) and the interest groups identified above (Sandall 1996). This coalescence created a 'window of opportunity' to introduce policy change (Kingdon 1995).

As technological interventions increased in the 1990s, consumer organisations came to play an even more prominent role in the childbirth debate, resulting in media and parliamentary attention. Medical dominance was questioned and the welfare state expressed support for less-powerful female actors – midwives and consumers. One result was a parliamentary enquiry to assess the most appropriate and cost effective use of professional expertise in the maternity domain. Where previous inquiries had tended to focus on mortality rates, this time normal pregnancy and birth were the centre of attention. The *Winterton Report* (House of Commons 1992) and the government's response, *Changing Childbirth* (DH 1993), critically reassessed the roles of health professionals and used the views and experiences of women in the creation of policy recommendations. Both reports concluded that there should be less focus on mortality rates as the major outcome measure and recommended a move towards a 'woman-centred' approach that offered women choice in place, type of service and 'continuity of care'. According to Annandale and Clark (1996: 424), this shift in thinking allowed 'the integration of feminist interests, the grass roots feelings of women, [and] the heart of midwifery philosophy' to be realised in practice.

It is also possible to see these recommendations as part of a broader reform effort emphasising cost-efficiency. For example, *Changing Childbirth* encouraged choice, personal continuity and control, all neo-liberal ideas that link with welfare pluralism and 'lean production'. It ignored the wider range of social and environmental effects on health highlighted in the *Winterton Report* in favour of a strategy that treated maternity care as a vehicle for the expression of consumer values (Streetly 1994). Viewed through this lens, policy-makers used the argument of women's interests to pursue particular management aims. Not surprisingly, the implementation of the *Changing Childbirth* policy has been patchy. Pilot schemes were not mainstreamed and large variations remain in provision of care. Childbirth interventions continue to increase (ONS 2003) and concerns exist about the retention of midwives.

More recently, Parliamentary Reports on maternity care have expressed concerns yet again regarding choice, rising caesarean section rates and inequalities in care (e.g. House of Commons 2003c). It is noteworthy that the new government policy separates out services for mothers from other women's health services (DH 2004). Legitimated by increasing evidence on the science of foetal programming (Godfery 2001), it argues that 'improving the health and welfare of mothers and their children is the surest way to a healthier

nation' (DH 2004). In essence, the new policy for maternity care espouses a public health model of midwifery. Such a model explicitly encourages an expanded midwifery jurisdiction in areas of care previously provided by GPs and health visitors and is supported by the increase in numbers of maternity assistants. This scenario is less the result of professional negotiations and consumer stakeholder power, and more that of the modernisation agenda in the NHS where hospital reconfiguration and refocusing of the work of GPs and obstetricians have left a vacant occupational space (Abbott 1988).

Finland

It is estimated that nearly 80 per cent of births in Finland are attended by midwives (Gissler 2005). Official statistics are not available as the publicly-provided birth care in Finland relies on midwives as sole attendants for all normal vaginal births and also in case of minor complications. Despite the focal role of midwives in birth care, home birth accounts for less than one per cent (Viisainen 2001: 1110). While Finnish women have begun to challenge the dominance of the medical definition of birth in the maternity care system, midwives have not joined in and articulated jurisdictional claims over 'non-medical normal birth', as has been the case in the UK. What are the dynamics of the Finnish approach to maternity care that produce this particular situation?

Finnish society is shaped by a state-centred strategy of making social and health policy, of which the formation of maternity care is but one example. Consensus-oriented negotiations, aimed at accommodating diverse class and gender interests, are an established feature of the political culture. The Finnish state has been both an engine of welfare policy and a site of negotiations, to which professional groups and other societal actors have been tied. Rather than 'women-friendly' in the simple meaning of the term, the relative social equality between men and women and social classes has been achieved through complex negotiations among Finnish trade unions, stakeholders in the economy and finance, political parties and interest groups. The accommodation of diverse societal interests in the organisation of healthcare has served as a counterweight to the position of the medical profession. Yet this has not necessarily been to the advantage of autonomous midwifery or alternative forms of maternity care.

In 1944, the Parliament adopted legislation that introduced free maternity and infant care. For a nation that was still waging war, such investment represented hope for the future welfare of the population. Private-practice municipal physicians lost ground to midwives, who gained a state mandate to provide both social and healthcare services to women during pregnancy and birth. For mothers, the new public health services represented a social obligation to seek care as much as a social right to receive it (Wrede 2001: 256). Emphasis on women's rights as citizens, not merely as mothers, occurred much later, with the introduction of municipal day care services in 1973 – a policy associated with women's equality in the labour market (Bergman 2002).

Free maternity care in the long run led to increasing hospitalisation of birth where obstetricians held sway. At the same time, the role of the

municipal midwife became narrowed to a focus on preventive care, a situation that led local health policy makers to question the need for their high level of competence. Lack of support from municipal decision makers, together with plans to increase physician involvement in primary care, resulted in the exclusion of municipal midwives from the new model of first-line care, enacted through the *Public Health Act* of 1972. A two-tier maternity care system was designed. Public health nurses, in collaboration with primary care physicians, were awarded responsibility for prenatal care during normal pregnancies; hospital-based midwives, in collaboration with obstetricians, were responsible for pregnancy complications and all births. The Act thus split the midwifery profession and fragmented maternity services. Paradoxically, the overall aim of Finnish healthcare policy at the time – to promote primary care – ended up paving the way for the increased medicalisation of pregnancy and childbirth (Hemminki *et al.* 1990).

The position of the state as a central site of negotiations between societal interests was reinforced as policy expanded to new areas in the 1970s. The creation of the municipal primary care system in 1972, for instance, was based on the implementation of social democratic ideals of equity and equal access. The primary care reform occurred at the same time as feminists raised the issue of public day care as the dominant 'women's issue' (Bergman 2002). Yet support for midwifery did not gain such a status; feminists instead criticised the patriarchal notion of the family inherent in the organisation of maternity care. Health policy makers responded by encouraging fathers to become more active parents in the early years of their child's life (Wrede 2001). A short leave for fathers in association with the birth of a child was introduced in 1978, and in 1980 the concept of 'parental leave' was created. In this reform the former maternity leave was lengthened and divided into two periods of which the first one was the actual maternity leave, intended for women after the delivery, whereas the parents were free to choose which of the parents would stay at home during the later, longer period. In addition to these arrangements, maternity care providers were encouraged to involve fathers throughout the childbearing process (Wrede 2001). Universalistic welfare policy thus served to politicise healthcare delivery and undermined the position of professional interest groups (such as midwives) in favour of state authorities.

All in all, subsequent reforms of primary care centres, including the recent neo-liberal reforms aiming at improving flexibility and cost-effectiveness, continue to maintain the two-tier character of the maternity care system. The issue of women-centred maternity care provided by midwives has not been formulated in feminist terms in the same way as it has in the UK (above) and Canada (see below).

In a comparative perspective, the lack of feminist debate around maternity care calls for an explanation. Our perspective suggests a few reasons. First, in a country where all women have had access to an extensive maternity service for practically no cost, and where infant and maternal outcomes are

among the best in the world, other goals such as public day care, workers' rights and equality in the family have topped the feminist agenda. Furthermore, the Finnish version of social equality resulted in feminists emphasising similarities in the interests of men and women (Bergman 2002). Yet an emphasis on women's role as childbearers has been difficult to combine with the social democratic rhetoric of sameness. In this context, a demand for choice in birth care has become framed as an individualistic, even elitist issue. Even though at times vocal, the only longstanding network of birth activists, *Aktiivinen synnytys* (Active birth), is small, with a revolving membership of roughly 400 members. Founded in the mid-1980s, the network has targeted 'birth culture' rather than social policy. In the few instances that birth activists have engaged in policy (Viisainen 2001: 1/10), they have lobbied against decisions to close down particular maternity units.

Our finding of weak feminist and general public support for an autonomous midwifery profession suggests that the politics of gender sameness has a significant impact on the organisation of maternity care services in Finland. In such an equality-driven society, reproduction and the organisation of maternity care remain oddly under-politicised.

The Netherlands

The Netherlands is well known among maternity care researchers and women's health activists for its unique system of maternity care. Unlike the other three countries analysed in this paper, the Netherlands actively promotes birth at home under the care of primary caregivers – midwives and GPs. Consequently, more than 30 per cent of births occur at home, the majority attended by midwives. The Dutch state has a history of preserving autonomous midwifery and birth at home through: (1) laws and regulations that give preference to midwifery care; (2) state support for the education of midwives and for the conditions of midwife practice; and (3) funding of research that demonstrates the safety and efficacy of midwife-attended home birth. All three suggest a relatively strong welfare state as the dominant stakeholder, similar in some respects to its Finnish counterpart discussed above, but quite different in its women-friendly as opposed to gender neutral focus.

State support for midwifery was established in 19th century legislation that defined the practice of medicine. In both the 1818 *Health Act* and the 1865 *Medical Act*, midwifery was defined as a 'medical' profession and given a well-defined sphere of practice. When the modern system of national health insurance was created in the 1940s, midwives were given preference as women's first choice provider and this arrangement persists to this day. Thus, a healthy Dutch woman opting for a home birth might not see a doctor at all during her pregnancy and birth. Midwives provide antenatal and postnatal care in the community and attend home births and short-stay hospital deliveries.

The Dutch have a national health insurance system, with a mixture of collective health insurance organisations (so-called Sick Funds) and commercial health insurers. A government organised committee – which includes

representatives from employers, unions, caregivers (of all sorts), hospitals, patient organisations, insurance companies and government officials – makes important decisions about what sort of care will be offered, by whom, and for what fee. This centralised control has been used to promote midwifery: women who expect a normal ('physiological') birth – as defined by an Obstetric Indications List – must receive their care from either a midwife or a GP. Specialist care can be used only when complications are present. This legislation limits competition, and more importantly, guarantees business for midwives.

The government also keeps a close eye on the conditions of midwife practice, adjusting policy in an effort to keep an adequate supply of midwives. In response to a recent shortage of midwives, the Minister of Health authorised both the creation of a new school of midwifery and an increase in the number of new students (from 120 in the 1990s to 220 in 2003–06). In conjunction with this increased flow of students into the profession, the government also improved the income of working midwives (De Vries 2005: 94–141). The desire to support midwives also prompted policy changes that increased the number of *kraamverzorgende* (post-partum caregivers) who assist midwives during the birth and support mothers and families in the postpartum period. The work of the *kraamverzorgende* makes the task of midwives easier during the postnatal period. As part of a conservative family-centred welfare state perspective, rather than enacting parental policies which would give fathers more time to spend with their family (as in the Finnish case), the Dutch state has spent its resources on the *kraamverzorgende*, a social support person/husband substitute available to the woman during and after childbirth.

A final source of government support for midwifery is the funding of research on the Dutch way of birth, research that guides policy decisions for the profession, including the working conditions of midwives (Bakker *et al.* 1996) and the effectiveness of the maternity care system (Wiegers 1997: 48). The latter concluded that, 'perinatal outcome was significantly better for planned home birth than for planned hospital births', for both first-time mothers and those with previous children.

Because of strong government support, medical-technological developments in maternity care have not had a major impact on midwifery. Abraham-van der Mark (1993) summarised:

> Although midwives lost ground in the twentieth century in other Western countries, Dutch midwifery was characterised by growing professionalisation: midwives' qualifications were increased, standards for recruitment and training were made more rigorous, and their organisation gained power.

The well-established position of Dutch midwives has resulted in a virtually non-existent consumer movement concerned with choice of maternity provider and birth place. The particular type of gendered policies of the Dutch state supported pregnant women's interest most of the time when it supported midwives. On occasion, when these two sets of interests were not

parallel or when the state failed to support midwifery, short-lived consumer groups sprang up (and rapidly disappeared): in the mid-1980s *Beter Bevallen* (with the double meaning of 'better delivery' and 'more pleasing') was organised, and in the late 1990s a group of parents and midwives created the *Stichting Perinatale Zorg en Consumenten* (Foundation for Perinatal Care and Consumers). The latter was a reaction to the declining home birth rate and the subsequent risk of the elimination of birthplace choice for Dutch women. It was this latter group, coupled with midwives' political activism, that encouraged the government to take seriously the complaints of midwives about their working conditions. The subsequent policies – increased salary and reduced caseloads – have been responsible for both stabilising the rate of homebirths and bolstering the midwifery profession (De Vries 2005).

Why has the Dutch government consistently supported midwifery and protected home birth? The answer lies in a mix of cultural ideas held by the general public and structural features of medicine. The Dutch are noted for their distinctive ideas about home, family, the efficacy of medicine and *zuinigheid* (thriftiness). If Finnish welfare policy in the 1970s had a gender-neutral emphasis, in the Netherlands an ideology of men and women's complementary roles in the family and in society has informed maternity care policy. This conservative welfare state ideology has shaped policies that have reinforced a view of birth that is home-based and family-centred (van Teijlingen 2003). Thus, as long as the policies are (seen to be) family-centred there is little need for consumers to put pressure on the political decision-making process.

Dutch ideas about *zuinigheid* imply more than just being cautious about spending money; it is also possible to be thrifty in one's response to other aspects of life. Dutch *zuinigheid* is associated with a very pragmatic approach to all social policy: decisions about everything from drug use, to euthanasia, to childbirth are made only after careful study of different approaches (De Vries 2005). While other countries were abandoning homebirth and midwifery for less than scientific reasons (Tew 1995), the Dutch examined these practices and found them to be safe and effective as well as family-centred. The Netherlands is also distinctive in the slow development of the specialty of obstetrics. Although Dutch obstetrics is now the equal of any in the world, it was not always so, a fact that allowed a strong profession of midwifery to be established and continue to exist autonomously into the 21st century.

Canada

Because Canada is a latecomer in designing a maternity care system that includes midwifery, the negotiated and gendered nature of that system domain reflects a more contemporary period. Even as late as the early 1970s when the Canadian government began to fund maternal services for all pregnant women, the system was created exclusively for medical and hospital approaches to maternity care (Benoit and Heitlinger 1998). This was but a more recent example of the exclusionary patriarchal social closure strategies (Witz 1992) that had been directed towards Canadian midwives since the turn of the 20th century.

First, the *Medical Practitioners Acts* of most provincial health ministries (the agencies that oversee health service provision) restricted the performance of 'maternity services' almost exclusively to licensed members of the College of Physicians and Surgeons until the early 1990s. Second, public funds for maternity care services have been available only for hospital services since the late 1950s and specific activities performed by licensed physicians since the early 1970s. So-called 'alternative' health services, such as midwifery, remained, until recently, uninsured in provincial healthcare plans. As a result, midwifery services have not been available, unless birthing women were able to pay privately and access them locally. Private-practice midwives also had to work outside the official healthcare system and formal healthcare settings (Benoit and Heitlinger 1998). Thus, through its systems of provincial health insurance and licensed Medical Acts, the Canadian welfare state enshrined medical dominance over the country's maternity care services.

In recent years, much to the chagrin of the medical profession, some provincial governments have enacted policies integrating certified trained midwives and a homebirth option into the formal healthcare system – either with protective licensing, public funding for midwifery services, or both. This includes midwifery care for the ante, intra and postpartum periods. In other words, the new Canadian midwives are legally able and in some provinces required to attend a certain number of both home and hospital births annually, while their physician counterparts are banned from attending homebirths by their professional licensing body.

Two intertwined pressures on the Canadian welfare state – cutbacks in federal health funds to the provinces, and an integrated consumer/midwifery social movement demanding greater choice in childbirth – helped to bring about this turn (Bourgeault *et al.* 2004). This is similar to Britain where the interests of a retrenched welfare state and consumers came together but, as noted above, was largely absent in the Finnish and Dutch cases.

The success of midwifery and consumer groups in shaping the health policy agenda of particular Canadian provinces resulted from several factors. The case of Ontario, the first province to legalise midwifery, is instructive. First, midwifery organisations and consumer groups garnered support from key actors within the provincial government who offered significant support for the integration of midwifery into the healthcare system. Support for birth activists was visible in the establishment and funding of midwifery policy committees, the purposive appointment of persons with pro-midwifery sentiments to these committees, and the government's response to these committee's recommendations (Bourgeault 2005). As noted in the British case, state support for the midwifery initiative was forthcoming for two main reasons. First, midwifery was regarded as cost-effective, which suited the government's rationalisation of the health-care system. Secondly, it made the government appear as 'progressive' by promoting women's rights. It is also not insignificant that the Ontario Ministers of Health throughout the midwifery integration process were strong feminists who were personally supportive of midwifery as a woman-friendly initiative.

Midwives can now practise legally in five Canadian provinces and midwives' services are now included as part of provincially-funded public healthcare services in four of these, while similar legislation is underway in several other provinces and territories. The midwifery integration process in Canada offers an example of a maternity care policy initiative fuelled by organised consumer support but also attractive to governments pursuing particular agendas. At the same time it is important to note that these changes have occurred against a backdrop of an overall reduction in the obstetric workforce in the 1980s that created a vacant jurisdictional space in maternity care division of labour. Many physicians – both GPs and specialists – have abandoned the practice of maternity care because of significantly higher malpractice insurance fees and the demands of obstetric care on one's personal life. In 1983, 68 per cent of family physicians attended births; by 1995 this number was reduced to just 32 per cent (Reid *et al.* 2001).

Canadian midwifery care, however, remains an alternative for a small albeit growing group of women. Registered midwives – like other healthcare providers – for the most part work in or near large urban centres. Their numbers are still small; currently they attend only two per cent of births nationally. So although the recent introduction of midwifery was a major consumer-driven and state-supported maternity care policy initiative, it has to date only had a small ripple effect on the national healthcare system. Indeed, the presence of midwives may cause further decline in GP services, leaving birthing women without any choice of health provider. Moreover, while the boundaries between midwives and physicians are being successfully challenged and re-negotiated, the latter still wield enormous power over the future direction that the country's maternity care system will take.

Discussion

Comparative analysis of the roles and responsibilities of midwives reveals significant cross-national variation in the social organisation of maternity care systems. The early English language sociological research largely focused on North America, where midwifery had been marginalised or excluded from the health division of labour and subsequently idealised as an authentic 'alternative' to medical control (Lay 2000). Research on the other side of the Atlantic reveals that midwifery has had other historical paths and holds multiple meanings today, resulting from conflict and negotiation at the micro, meso and micro levels of healthcare organisation. Our 'decentred method' makes it possible to shed light on how different welfare states organised their respective maternity care services, how boundary disputes in the health division of labour were contested, negotiated and renegotiated (or not), when and where consumer groups mobilised around maternity care issues and variation in the gendered dynamics across all three levels of analysis. Welfare regimes are revealed as sites of political struggles that involve complex and

interactive relations between the state itself, the historically male-dominated professions, the contested female occupation of midwifery and the women who use maternity services.

World War II and its aftermath was associated with the reshaping of the health-care systems in our European cases, generating reforms that emphasised state responsibility for the provision of healthcare. In Europe, this fact overrode other emerging cultural differences in welfare regimes. In Canada, the war lacked such collective impetus. Notice, for example, how the UK – following the Northern European tradition of integrating midwifery into the official health service – has kept midwifery alive, while in Canada, until recently, midwifery suffered under the North American approach that favoured market-based physicians as providers of maternity care. Recent moves by provincial governments in Canada to support midwifery have had as much to do with efforts towards cost containment and the rational use of resources as to a 'women-friendly' welfare state approach to re-organising maternity care. In terms of the theory of professions, Canada serves as an example of a system in which a 'vacant jurisdiction' (Abbott 1988) is emerging in maternity care, because more and more physicians are choosing not to offer the services, and because their opposition to midwives is not as strong as before. Midwives have been seen by some governments as a cost-effective way to help fill this void.

But this is not the full story. Our analysis also highlights the multiple ways in which those who use maternity care services have made organised efforts to change the way care at birth is given. Again in the Canadian case as well as the UK, there have been active birth movements organised as consumer groups that support midwifery as an ideal means of achieving women-centred care. Consumer organisations have played an increasing role in the debate around changing maternity care practices, resulting in media as well as government interest (Bourgeault, DeClercq and Sandall 2001). Birth activists have hardly played a role as pressure groups in Finland and the Netherlands, however, as countries where the government continues to intervene in maternity care in ways that limit market principles. In the Finnish case, maternity care policy is focused on equality between parents during the childbearing period, which undermines collaboration between midwives and birthing women, and results in a maternity care system splintered between primary care providers and hospital-based obstetricians and midwives. The Dutch welfare state, while also adopting a lead role over the organisation of maternity care, has historically favoured a more gender-specific and in many ways more woman-friendly approach, based on an ideology of complementary roles between men and women. By way of contrast, the UK and Canada have emphasised market principles, making women important as consumers, which frames the issue of maternity care in a more individualistic way.

In all four health systems midwifery is constantly redefined in relation to medicine, requiring a set of theoretical concepts that draw from all three theories mentioned in the introduction of this paper. Some have argued that the overriding logic of health systems in high-income countries is the logic of

the medical professions, even when 'pockets' for other logics emerge from time to time (Griffiths 2003). The idea of woman-centred care has made inroads into the organisation of maternity care, but, lacking the support of arguments such as a possibility for cost containment, it could not compete with the logic of medicine. Similar to work by Allen (1997) on negotiation over the nursing-medical boundary, our analysis suggests that the logic of medical dominance can nevertheless be successfully challenged under certain circumstances, for example when maternity care is viewed as a social entitlement by the welfare state and where activists see midwifery as a vehicle to achieve accessible care. At present, however, the Netherlands is the only welfare state that truly supports midwifery as the favoured woman-centred solution for the provision of maternity care, supported interestingly enough, by a fluid consensus among state policy makers, GPs, obstetricians, midwives and consumers at large, in a structure that equalises the power of each partner to negotiate. The design of maternity services in the other three countries remains an outcome of often-times competing welfare state interests, professional boundary struggles and changing consumer interests surrounding pregnancy and childbirth.

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Notes

1 The United States was purposely excluded because it is an outlier in regard to many of these health system features.
2 In this context, we use 'touchstone' to refer to midwifery as the key for understanding the variation in maternity care systems across these four developed welfare states.

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