

‘The money follows the mum’

Maternal power as consumer power

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In her 1984 article ‘Pregnant Embodiment: Subjectivity and Alienation’, Iris Marion Young contended that ‘pregnancy does not belong to the woman herself’ within patriarchal Western institutions of modern medicine. ‘It is a state of the developing fetus, for which the woman is a container; or it is an objective, observable process coming under scientific scrutiny; or it becomes objectified by the woman herself as a “condition” in which she must “take care of herself”.’¹ Such concerns around women’s lack of autonomy, control and decision-making power in encounters with obstetrical medicine have been central to feminist campaigns around reproductive health from at least the 1970s onwards, as feminists have criticized the hierarchical structuring of the doctor–patient relation (especially when the doctor is male), the infantilization and disciplinary treatment of pregnant women, and the ‘medicalization’ of childbirth through unnecessary or excessive use of instruments, technologies and drugs.

In some respects, the recommendations of the National Maternity Review published in March 2016 – *Better Births: Improving Outcomes of Maternity Services in England*² – may seem to indicate that feminist calls for the ‘de-medicalization’ of childbirth, and the empowerment of pregnant and birthing women, have been absorbed into mainstream health institutions and state policy. The key message of the Review is that in order to improve, maternity services must provide more ‘personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information’, and moreover greater ‘continuity of care, to ensure safe care based on a relationship of mutual trust and respect in line with the woman’s decisions’.³ But despite this ‘feminist-friendly’ veneer, there are questions to ask concerning the political and economic motivations behind such recommendations and the consequences of their implementation. One feature of the Review is particularly troubling: the proposal that pregnant women’s choices can best be realized through the introduction of a NHS Personal Maternity Care Budget.

The authors of the Review report acknowledge that there is already a ‘long-standing expectation that women should be given a full choice of place of birth: home birth, midwifery unit and obstetric unit’,⁴ but also stress that in reality such choices are not always made accessible or available. Accordingly, they suggest that giving women control of the ‘money used to buy [their] care’ would ‘give impetus to choice’⁵ and ‘ensure women are able to make their choices with the knowledge they will be

realized'.⁶ Currently, 'low-risk' births cost the NHS around £3,000 as the standard tariff, and the Personal Maternity Care Budget would work within this 'existing resource envelope'.⁷ In collaboration with a midwife or doctor, the pregnant woman would draw up a maternity plan, 'working out exactly how and on what [the money] will be spent', and choosing between 'NHS-accredited providers' in their locality. The woman would then receive the 'means of making a choice, such as an electronic code to use on a secure website'.⁸ The scheme, the report clarifies, would be voluntary, and 'the submission of invoices, coding and other normal contracting logistics would occur as now'.⁹ Four pilot schemes are to be implemented next year, with full roll out due in 2018/19.

Gender and spending

Personal health-care budgets are not new: they have already been introduced for people with long-term conditions and health needs, who can use their budget to procure a range of items and services, including therapies, personal care and equipment.¹⁰ And indeed the report speaks of 'a strong synergy between the Review's proposal for NHS Personal Maternity Care Budgets to support increased choice and control for women, and the established purpose and objectives of the wider personal health budgets programme across health and social care'.¹¹ Given that personal health budgets have already been in existence for some time, then, one might ask why the proposal for their extension to maternity care attracted so much media attention when the Review report was published in March, with various headlines such as 'Mums-to-be will be given £3000 to spend on birth of choice'.¹²

The level of media interest can largely be attributed to the gendered politics of pregnancy and maternity, and sexist assumptions about women's judgement more generally. This is evident not only in paternalistic interventions questioning whether pregnant women will be capable of making 'safe' choices for themselves and their fetuses or babies,¹³ but moreover in the derisory depiction of pregnant women 'shopping' their way through pregnancy and birth under the proposed scheme. Pregnant women and mothers are already relentlessly bombarded by marketing operations pushing 'must-have' items from stretch-mark cream to baby gyms. Reinforcing this alignment of maternity with consumption, many newspapers have envisaged pregnant women embarking on a '*Sex and the City*-style shopping trip',¹⁴ gaily spending their Personal Maternity Care Budget on hypno-birthing, birthing pools and acupuncture, even though such therapies and methods are not in fact explicitly mentioned in the Review.

Of course, the frivolous 'festival of shopping'¹⁵ that the Personal Maternity Care Budget scheme would supposedly unleash is a journalistic fantasy, but the Review does unequivocally frame the 'empowerment' of pregnant women in terms of their power as consumers of health services, with the potential to drive competitive internal markets within the NHS and 'incentivise the delivery of high quality care'.¹⁶ Women will become the 'purchaser' to whom the provider will be accountable: 'there is a need to ensure that the money follows the woman as far as possible, so as to ensure women's choices drive the flow of money'.¹⁷ The vision is that pregnant women's spending choices will drive out 'inefficiencies' and unpopular or inadequate services, whilst also expanding market choice through encouraging new providers on the scene. Clinical Commissioning Groups, the Review report states, 'may need to look to alternative and innovative providers such as midwifery practices and social enterprises to provide genuine choice for their community'.¹⁸

Given the unpredictable element of pregnancy, labour and childbirth, practical questions quickly come to the fore. What happens when a pregnant or birthing woman exceeds or 'overspends' her allocated budget, or simply changes her mind as

events unfold, or her 'birth plan' becomes untenable? The report does reassure that if a woman's care needs 'proved to be greater than standard care, her transfer to another provider would be expected, and the payments made pro-rata'.¹⁹ But when even the authors of the proposal acknowledge the likelihood of planned maternity budgets going awry, it begs the question as to why pregnant women should be involved in NHS budgeting in the first place, especially in light of the likely costs and burden of regulating this additional layer to the administration of maternity care. The case for involving people with long-term, consistent, foreseeable health needs in planning their allocated health-care budget does at least make some sense from the point of view of the 'service-user'; but in relation to maternity care, it is more difficult to see any reasonable justification on practical grounds.

Choice and the marketization of public health

One reason provided, as we have seen, is that giving pregnant women some financial control will further 'empower' them to feel more confident that their choices will be realized, but this is an extremely dubious claim. It does seem plausible that many women, when interviewed about their experiences with NHS maternity care, would state that they want to be taken seriously and given more say over what happens to their bodies and the bodies of their foetuses and children. For instance, the report confirms that the women consulted as part of the Review 'often felt pressurized by their midwives and obstetricians to make choices that fitted their services' and that 'above all, women wanted to be listened to'.²⁰ But the authors are quick to interpret this as a kind of customer complaint that could be addressed through better digital platforms, personal financial control, and longer lists of providers to choose from, when there seems to be no real evidence that this is what women need or want. Indeed, the report itself admits that the key message from the Review's consultation with women was for 'safety and continuity of care', that 'women's preferences for other service attributes vary more'.²¹

Accordingly, as the Personal Maternity Care Budget proposal seems to be almost entirely lacking in any kind of meaningful research or practical sense, it only makes the economic logic behind it more obvious. The extension of personal healthcare budgets to maternity care reveals all the more clearly the underlying economic function of such budgets, which is to further conscript users of health services (in this case pregnant women) into the marketization of public health, in line with the Health and Social Care Act of 2012 designed to accelerate 'patient choice and competition'.²² Even when a pregnant or birthing woman's 'care needs' turn out to be different to what was initially anticipated and budgeted for, nevertheless, her preliminary choices will have power in determining the providers and services that are commissioned in her locality and the 'efficiencies' that are made, as some services are driven out altogether.

Moreover, the Review makes a virtue of the fact that the proposed move away from obstetrical settings towards midwife-led care will be much cheaper. The authors clearly envisage 'more births taking place in the community, i.e. in midwifery care and at home',²³ and openly declare that 'care in these settings costs less' and 'is essential to meet the coming efficiency challenge ... The review considers that the implementation of its recommendations are essential to deliver maternity services' share of the agency spending reductions announced by the Department of Health'.²⁴ Indeed, despite the authors' vision of more demand and need for midwifery care, they propose that 'a significant increase in the midwifery workforce is not required'.²⁵ This is a pretty remarkable statement when 'over two-fifths of maternity units', according to the Royal College of Midwives, 'had to close temporarily during the last year because they couldn't cope with the demand'.²⁶

Reproductive politics and feminist strategy

As a cost-cutting manifesto that contributes to the general drive towards privatized or marketized public health, there is clearly much for feminists to oppose in the National Maternity Review. But given the ease and apparent sincerity with which it formulates its economic ideology in the language of women's 'control' and 'empowerment', the Review also indicates a serious need for feminists to critically address the central role that notions of 'empowerment' and 'control' continue to occupy within feminist reproductive politics. Women's health-care movements since the 1970s have, in the words of Adrienne Rich, made important and 'strong connections between knowledge of our bodies, the capacity to make our own sexual and reproductive decisions, and the more general empowering of women'.²⁷ But Rich and other feminists have also been highly aware of the ways in which 'the principle of individuality and control over one's own body may be perverted into what is truly bourgeois individualism'.²⁸

This is clearly exemplified in the National Maternity Review's consistent depiction of the pregnant woman as a privileged 'savvy consumer',²⁹ who on the one hand expects to be presented with a range of competing providers and 'digital tools to help empower them in their decision-making',³⁰ and on the other hand actively welcomes 'help to give up smoking, having a healthy diet and being physically active'.³¹ The class-based component of this vision is obvious, and with 'control', it seems, comes a series of disciplinary imperatives and an individualized 'responsibility which pregnant women must accept'.³² 'Personal health and fitness are integral to safe and fulfilling childbearing',³³ the report emphasizes, with the implication that those who do not accept the 'right' advice and thus make the 'wrong' choices become legitimate targets for blame if things do not go as desired or expected. Indeed, advocates of 'natural childbirth' have at times fed right into this way of thinking, putting pressure on pregnant women to follow strict lifestyle guidelines and refuse pain relief and medical



Argelia Bravo, *Sí nos importa el bledo*, video still, Venezuelan Pavilion, Venice Biennale, October 2015

assistance during labour, with many women reporting feelings of guilt and failure if they do not fulfil the 'natural' ideal.

Of course feminists can always protest that this kind of scenario is miles away from what Rich and other advocates for women's reproductive freedom have had in mind, and insist upon alternative or 'properly feminist' meanings of bodily autonomy or maternal power premised upon solidarity and relationality. But the space for articulating such alternatives is hard to find, and, as the Maternity Review shows so clearly, support for women's autonomy or empowerment can be quickly seized upon by market champions and distorted through the prism of consumer power. As such, there is a strong case in the current climate for resisting the language of individual control and empowerment in relation to maternity care, and replacing it with a renewed focus on *health equity*: putting the weight of feminist politics behind social models and standards of health that transcend private economic interests and challenge social divisions based on differing access to power and resources.

There is, however, a lot at stake in abandoning, even quietening, talk of personal control and bodily autonomy within the sphere of reproductive politics. As Rosalind Petchesky asked almost forty years ago: 'can we really imagine the social conditions in which we would be ready to renounce control over our bodies and reproductive lives?'³⁴ To illustrate how unsettling or wrong this kind of move can feel, she points to Alison Jaggar's sketch of a 'Marxist feminist' defence of abortion, which suggests that the 'right' of women to an abortion is contingent upon 'women's situation in our society', and hence that 'if the whole community assumes the responsibility for the welfare of mothers and children, [then] the community as a whole should now have a share in judging whether or not a particular abortion should be performed.'³⁵ For Petchesky such a proposal is 'disturbing' because of the 'level of reality most immediate for individual women: that it is their bodies in which pregnancies occur'.³⁶ Control over reproductive decisions, she insists, has to do not only with the social relations of reproduction but moreover with 'women's bodies as such', and 'as long as women's bodies remain the medium for pregnancies, the connection between women's reproductive freedom and control over their bodies represents not only a moral and political claim but also, on some level, a material necessity.'³⁷ Petchesky's conclusion, then, is that whilst in the long term feminists must ask 'whether women's control over reproduction is what we want, whether it is consistent with equality', in the short term 'we have never experienced the concrete historical conditions under which we could afford to give it up'.³⁸ As such, despite the real tensions between feminist arguments which emphasize the social relations of reproduction, on the one hand, and those stressing women's individual control over their bodies, on the other, 'neither is dispensable for feminists, both are essential'.³⁹

How should we respond to this conclusion in the UK today? With regard to abortion, the bodily autonomy principle clearly remains a vital element of feminist politics given that a women's 'right to choose' free, safe and legal abortion is still constantly under threat; it is certainly much more contested than women's 'right to choose' where to give birth or how their births should proceed. Further, it is difficult to imagine a point in the future when the Department of Health would include abortion services within a personal health-care budget scheme; hence the 'right to choose' in the case of abortion is much less likely to be re-framed as a matter of consumer power driving competition within an expanding market of 'innovative' public health providers. But with regard to maternity services for women who continue being pregnant and go on to give birth, the strategic value of asserting women's right to, or need for, choice and individual control is arguably more ambiguous, when such assertions are so easily co-opted by an economic programme that can only benefit a small group of elite or 'savvy' pregnant women who exercise their maternal power as

consumer power. Petchesky is surely right to claim that as long as patriarchal power structures remain, feminists cannot afford to abandon the general principle of control over our bodies and reproductive capacities. But in the current political context of health care in the UK, as state and commercial interests become ever more aligned, the political risks of affirming women's need for individual or personal control are as high, if not higher, than they have ever been.⁴⁰

Notes

1. Iris Marion Young, 'Pregnant Embodiment: Subjectivity and Alienation', in *On Female Body Experience: 'Throwing Like a Girl' and Other Essays*, University of Chicago Press, Chicago, 2005 (1984), p. 46.
2. The National Maternity Review was launched following an inquiry in 2015 that investigated preventable perinatal deaths at the University Hospitals of Morecambe Bay NHS Trust. The final report of the Review can be found in full here: www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf.
3. National Maternity Review report, pp. 7–8.
4. *Ibid.* p. 45. This is endorsed by the National Institute for Health and Care Excellence (NICE) clinical guideline 190 ('Intrapartum care for healthy women and babies', section 1.1). The Review report claims that in 2012, 87 per cent of births took place in NHS obstetric units. Although 96 per cent of trusts offered home births, 2.4 per cent of births were at home (p. 19).
5. National Maternity Review report, p. 92.
6. *Ibid.*, p. 44.
7. *Ibid.*, p. 117.
8. *Ibid.*, p. 118.
9. *Ibid.*
10. For more on personal healthcare budgets, see www.nhs.uk/choiceintheNHS/Yourchoices/personal-health-budgets/Pages/about-personal-health-budgets.aspx.
11. National Maternity Review report, p. 120.
12. *Telegraph*: www.telegraph.co.uk/news/health/news/12169112/Mums-to-be-will-given-control-of-3000-to-spend-on-birth-of-choice.html.
13. As Rebecca Shilling writes in the *Guardian*: 'Wherever we place ourselves on the natural to medicalised birth spectrum, the narrative is usually the same. Silly women with their unrealistic and downright irresponsible ideas about birth can't be the ones who decide what happens to their bodies in pregnancy because it's just not safe for the baby.' www.theguardian.com/commentisfree/2016/feb/23/women-choose-maternity-care-cumberlege-personal-birth-budgets.
14. This is how 'Glosswitch' writing in the *New Statesman* puts it: www.newstatesman.com/politics/health/2016/02/it-s-not-self-indulgent-prioritise-choice-maternity-care.
15. See, for example, the *Telegraph*: www.telegraph.co.uk/women/family/should-pregnant-women-be-given-a-3000-birth-fund-by-the-nhs.
16. National Maternity Review report, pp. 12, 91.
17. *Ibid.*, p. 12.
18. *Ibid.*, p. 45.
19. *Ibid.*, p. 119.
20. *Ibid.*, p. 32.
21. *Ibid.*, p. 30.
22. See the Health and Social Care Act 2012: www.legislation.gov.uk/ukpga/2012/7/contents/enacted.
23. National Maternity Review report, p. 88.
24. *Ibid.*, p. 98.
25. *Ibid.*, p. 96.
26. This is from the Royal College of Midwives' website: www.rcm.org.uk/news-views-and-analysis/news/maternity-services-overworked-understaffed-and-struggling-to-cope-shows.
27. Adrienne Rich, 'Ten Years Later: A New Introduction', *Of Woman Born: Motherhood as Experience and Institution*, Virago, London, 1992, p. xv.
28. Rosalind Petchesky, 'Reproductive Freedom: Beyond "A Woman's Right to Choose"', *Signs*, vol. 5, no. 4, 1980, p. 671.
29. National Maternity Review report, p. 34.
30. *Ibid.*
31. *Ibid.*, p. 85.
32. *Ibid.*, p. 4.
33. *Ibid.*
34. Petchesky 'Reproductive Freedom', p. 677.
35. Alison Jaggar, 'Abortion and a Woman's Right to Decide', in Carol C. Gould and Marx W. Wartofsky, eds, *Women and Philosophy*, Capricorn Books, New York, 1976, pp. 351, 356, 358, quoted in Petchesky 'Reproductive Freedom', p. 677.
36. Petchesky 'Reproductive Freedom', pp. 677–8.
37. *Ibid.*, p. 667.
38. *Ibid.*, p. 663.
39. *Ibid.*, p. 678.
40. 'The Money Follows the Mum': Simon Stevens, NHS chief executive, quoted in the *Telegraph*: www.telegraph.co.uk/news/health/news/12169112/Mums-to-be-will-given-control-of-3000-to-spend-on-birth-of-choice.html.