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Medical dominance and neoliberalisation in maternal care provision: The evidence from Canada and Australia

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Abstract

Since the 1970s, governments in many high-income countries have implemented a series of reforms in their health care systems to improve efficiency and effectiveness. Many of these reforms have been of a market-oriented character, involving the deregulation of key services, the creation of competitive markets, and the privatization of health and social care. Some scholars have argued that these “neoliberal” reforms have unseated the historical structural embeddedness of medicine, and in some cases even resulted in the proletarianisation of physicians. Other scholars have challenged this view, maintaining that medical hegemony continues to shape health care provision in most high-income countries. In this paper we examine how policy reforms may have altered medical dominance over maternity care in two comparatively similar countries – Canada and Australia. Our findings indicate that neoliberal reforms in these two countries have not substantially changed the historically hegemonic role medicine has played in maternity care provision. We discuss the implications of this outcome for the increased medicalisation of human reproduction.

Keywords

Canada; Medical dominance; Maternity care provision; Australia; Neoliberalisation; Medicalisation

Introduction

The concept of medical or “physician” dominance can be traced to the beginning of the 1970s to the writings of Eliot Freidson (1970a, 1970b). A profession is an elite category of occupation that has assumed a dominant position in a division of labour. Freidson defined “professional dominance” as the way in which certain professions control the content of their work (autonomy), define limits of the work of others (authority), and act as state-supported experts regarding the public’s health (altruism) (Freidson, 1970b). According to Freidson, medical professionals have achieved a special elite status among politicians,

government bureaucrats and the general public, who have become convinced of medicine's superior expertise and the trustworthiness of its members.

Professional medical dominance of decision-making about maternity care predates the development of the modern welfare state. Two distinct but concurrent processes facilitated this medical hegemony of maternity care in earlier stages of industrial capitalism. First, pregnancy and childbirth became defined as an illness event that required frequent medical supervision and technological intervention (Donegan, 1978; Oakley, 1984). Second, there was a shift in birth place from the home, where the birth attendants were visitors of the pregnant woman, her family and extended kin, to the hospital, where the pregnant woman was now the 'guest' and was expected to follow 'house rules' established by physicians and hospital administrators (Sullivan & Weitz, 1988). Further to this, hospital-based care allowed for the utilization of new scientific techniques, technological aids, and pain-relieving drugs, as well as the provision of social care following childbirth (McCalman, 1998; Walzer Leavitt, 1986). By means of a lengthy public health campaign, women became increasingly convinced of the need to have their pregnancies monitored by physicians (Barker, 1998). These phenomena suggest that the medicalisation of human reproduction is perhaps more prominent than that of any other health event (Kent, 2000).

The medicalisation of childbirth has been criticised for its negative effects on women's satisfaction with the birth experience (Declercq, Sakala, Corry, & Applebaum, 2006), as well as other negative psychological and social consequences, including disempowering birthing women (Bourgeault, Benoit, & Davis-Floyd, 2004; DeVries, Benoit, Van Teijlingen, & Wrede, 2001; Van Teijlingen, Lowis, McCaffrey, & Porter, 2000), and subordinating a range of other, primarily female, birth attendants such as midwives (Oakley, 1976; Sandall, 1995; Willis, 1983). In addition, the medicalisation of childbirth has been argued to increase inequities in access and quality of maternity care, in particular for women of Aboriginal background¹ and other ethnic minority groups, as well as those residing in rural and remote areas and the inner city, where traditional maternity care systems were undermined but physicians were reluctant to set up practices (Benoit, Carroll, & Chaudhry 2003; Benoit, Carroll, & Westfall, 2007; Bourgeault et al., 2004; O'Neil & Kaufert, 1996).

Willis (1989) put the 'golden age' of medical dominance over pregnancy, childbirth and other health events roughly between the 1920s and 1970s; this was when the medical profession in Anglo-American societies enjoyed unchallenged state patronage and support (Willis, 2006). During this period, the medical profession in countries such as Canada and Australia governed the health division of labour, including other maternity care providers, by acting as a state within a state, or government-by-proxy (Kettl, 1988; Salamon, 1981). Because medical dominance of health system governance was more technocratic than democratic, it provided little opportunity for public participation.

¹Aboriginal or Aborigine refers to indigenous peoples around the world. Australian Aborigines/Australians are a group of people who are identified by Australian law as being members of a race indigenous to the Australian continent. Aboriginal peoples is a term used by the Canadian government to refer to three subgroups: First Nations, Inuit, and Métis. In this paper we use the term "Aboriginal" to refer to the indigenous peoples of both Australia and Canada.

Medical dominance and the consumer challenge

The cultural milieu of advanced industrial capitalist societies in the late 1960s and early 1970s was marked by a general lessening of trust in professional authority, an unprecedented decline in respect for medicine, and a growing recognition of the emotional, social and spiritual components of life and healing. This shift found expression in, among other things, a birthing consumer movement, which promoted birth as a natural biological process, questioned the need for physician attendance at all births, and made the case for different approaches to childbirth. Some came to believe that childbirth should ideally occur at home without medical intervention, and be celebrated as a woman's achievement, with her partner, close family and friends.

Beginning in the early 1970s, governments in a number of high-income countries, including Britain, Canada, New Zealand and Australia, also began taking an increasingly active role to control the influence of medicine. The interests of competing professional groups such as nurses and midwives were supported by ministries of health and other governmental bodies, often in vocal opposition from physicians (Bourgeault et al., 2004; Brodie & Barclay, 2001; Tracy, Barclay, & Brodie, 2000). At the same time, governments in these countries made opportunities available for patients (now referred to as 'health consumers') to become formidable players in the negotiation of their health care (Bury, 2004). In short, pregnant women could no longer be easily dismissed as 'passive recipients' of doctors' services. They had become 'reflexive consumers' (Zadoroznyj, 2001) and many even developed activist roles based on their past childbearing experiences.

Medical dominance and neoliberalization

This re-examination of medicalised maternity care practices and the concurrent shift in thinking about medical dominance over maternity care was nested within governments' larger economic and political projects to reform their country's private and public sectors. This strategy has come to be referred to as neoliberalism, which "denotes a politically guided intensification of market rule and commodification" (Brenner, Peck, & Theodore, 2010, p. 3). Among other things, neoliberalism involved the change from a Fordist to a post-Fordist economy, that is, one characterised by flexible production designed to respond to diverse consumer demands and fragmented markets spread across the globe (Harvey, 2005; Williams, 1994). Post-Fordism entailed a series of labour-market reforms that while initially deployed in unionised labour markets were eventually applied to reform professional labour markets as well, including public health management (Coburn, 2006; Willis, 2006).

However, we have to be careful not to view neoliberalism in a monolithic fashion. Rather, it involves heterogeneous forms of "neoliberalisation" that emerge and take shape through their collision with diverse institutions located in different geographical socio-political landscapes (Brenner et al., 2010). Neoliberalisation processes are closely linked to processes of 'regulatory restructuring' – i.e., "the recalibration of institutionalised, collectively binding modes of governance and, more generally, state-economy relations, to impose, extend or consolidate marketised, commodified forms of social life" (Brenner, Peck, & Theodore, in press, p. 4). In this paper we examine the link between processes of neoliberalisation and

medical hegemony over maternity care provision across different welfare states. Specifically, we ask whether neoliberalisation places countervailing or complementary pressures on the medicalisation of childbirth in two high-income countries – Canada and Australia. Both of these countries have highly medicalised maternity care systems, and face similar challenges regarding equity in maternity care provision due to their colonial heritage and the geographical dispersion of their respective populations; as a result, culturally-inappropriate and mal-distributed maternity services for Aboriginal and rural and remote women are prevalent in both countries (Benoit, Carroll et al., 2007; Department of Health and Aging, 2008, 2009). In addition, both countries have undertaken extensive neoliberal health reforms in recent decades, albeit of differing forms. In either case, the ostensible aim has been to increase efficiency and effectiveness and at the same time expanding public choice and democratizing health care governance.

These similarities between the Canadian and Australian maternity care systems provide an opportunity for the authors to reflect on the relationship between medical dominance and neoliberal reform. Some Australian researchers argue that the medical profession has retained its dominance in the health division of labour despite neoliberal reforms to health policies in that country (Willis, 2006). Canadian researchers demonstrate more differentiated impacts on medical dominance: some argue that physicians have become proletarianised (i.e., its empowered status and professional dominance have been eroded) by the new managerialism espoused by Canadian governments (Coburn, 2006), while others highlight a continued embeddedness of medical dominance in primary health care in Canada (Bourgeault & Mulvale, 2006). This division in the Canadian maternity care literature suggests the need for more comparative research between countries with a broadly similar background in regard to a history of medical dominance and experimentation with neoliberalism (Willis, 2006).

With this in mind, we discuss below how the “moving map” of neoliberalisation (Harvey, 2005, p. 88) has played out for the organization of maternity care in Canada and Australia. While there are a number of distinct dimensions of the neoliberalisation process (Brenner & Theodore, 2005) below we focus only on the one that is highly relevant to our analysis – regulatory experimentation.

Neoliberalisation and regulatory experimentation in maternity care

In recent years, Canadian and Australian governments have been involved in regulatory experimentation in maternity care in different ways. We examine these developments in turn.

Medical dominance of maternity care in Canada, while significantly predating the welfare state, became enshrined and solidified within the package of policies and regulations that accompanied the adoption of universal health care, known as ‘Medicare’, implemented and formally adopted in 1972 (Badgley & Wolfe, 1967). While often referred to as a single health care system, in fact, funding and delivery of insured services are provincial/territorial matters. Most physicians work in private practice, with their services paid from the provincial/territorial insurance plans. Funding for the insurance plans comes from the

general revenues of the provinces/territories, with additional transfer payments from the federal government through the 1995 Canada Health and Social Transfer Act (Bill C-76).

It is crucial to note that, though initially resistant to the implementation of a ‘socialised’ health care system for Canada (there was even a doctors’ strike to protest the government Medicare plan), physicians across the country eventually gained much by this new welfare state policy (Naylor, 1986). First of all, their services were reimbursed through the public purse, thereby virtually guaranteeing them economic security. Secondly, Medicare solidified physicians’ dominance over maternity care services, granting them a monopoly over the provision of the country’s care of pregnant women, which was reinforced by the reimbursement of physicians but not midwives (or nurse practitioners) for services rendered, limiting women’s choices regarding style and place of care. Thirdly, physicians retained their right to remain private entrepreneurs, establishing their practices wherever they deemed appropriate, where they would provide a range of medical services to women that physicians themselves, not the women, decided upon as necessary. This point is notable, as it did nothing to alleviate the pre-existing disparity in the availability of physician services between rural and urban areas. Finally, the hospitalization of childbirth had long been a goal of Canadian medical professions. Medicare solidified the medically dominated hospital as the linchpin to the entire maternity care system (Bourgeault et al., 2004; Benoit, Carroll et al., 2007).

Provincial and territorial governments throughout the 1970s into the 1980s experimented with a number of cost-control initiatives to counter continuing economic escalation, including global hospital budgets and aggregate caps on physician salaries through negotiations with provincial medical associations. However, such initiatives did not have a fundamental impact on the rising health care costs (Barer & Stoddart, 1991). Some provincial and territorial governments challenged the restricted professional labour market by passing legislation to either widen the role of other care providers (e.g., nurse practitioners) or, in the Canadian case, certify a brand new competitive healer – the midwife.

Legislative changes for the inclusion of midwives as primary maternity care providers in Canada began in the early 1990s. However, these changes did not occur synchronously across the country since each province/territory has jurisdiction over its own health care services. Where midwifery has become regulated, a new type of midwife – the certified midwife – has emerged. Currently, six provinces and one territory have certification procedures in place for midwives (Bourgeault et al., 2004) and most of these jurisdictions fund midwifery services through provincial and territorial health insurance plans. Midwifery services are not publicly covered elsewhere in the country; instead, pregnant women and their families have to pay for their care out of pocket (Canadian Institute for Health Information, 2004a).

Pay structures for midwifery care also vary across regions. In Quebec, certified midwives are largely salaried practitioners working in birthing centres, and home birth attendance is not covered under current legislation (Vadeboncoeur, 2004). By contrast, in Ontario and British Columbia, certified midwives are paid per client course of care, and are permitted to attend births either in clients’ homes or in hospital. Midwives in both Ontario and British

Columbia have adopted a ‘woman-centred care’ model which emphasizes: continuity of care (with the same midwife or team of midwives caring for the woman throughout her course of care); informed choice (whereby the woman is given the information she needs to make decisions regarding diagnostic tests, interventions and procedures); and choice of birth place (home or hospital, for those who qualify for home birth on the basis of their obstetrical history, health, and other criteria). Midwives working in these two jurisdictions tend to work in independent group practices of two, three and as many as eight midwives as part of a team, similar to group practice arrangements among Canadian physicians. In Manitoba, midwives are regulated, enjoy both hospital and home birth privileges, are, paid by salary and directly employed by provincial health authorities. Discussions are currently underway with rural health authorities to expand into First Nations communities there.

While seen by many as a major achievement for pregnant women in Canada in that midwifery care is now a choice in many regions and services reimbursed through the public purse, the impact of this change to date has been small, with less than five percent of births attended by a certified midwife (Canadian Institute for Health Information, 2004b). Some estimate that as many as 40 percent of women who want to see a midwife in Ontario are currently unable to find one, and other provinces are also experiencing a situation where demand far outstrips supply (Association of Ontario Midwives, 2007).

In an effort to improve health equity and accessibility of health services for its vulnerable populations, the federal government invested funds in the recent decade towards the development of primary health care teams (PHCT) in various provinces. In Canada, maternity care is one of the key areas targeted for primary care reform. Multidisciplinary Collaborative Primary Maternity Care Project (MCPMCP), 2005; Multidisciplinary Collaborative Primary Maternity Care Project, 2006. The South Community Birth Program, which opened its doors in Vancouver in 2004, is a case in point. The program provides multidisciplinary collaborative care to low-risk childbearing women. Yet, as Bourgeault and Mulvale (2006) note, such teams have not changed the structural embeddedness of medical dominance, and their availability and sustainability over the long run remains an issue.

While there has been a trend in Canada to deregulate maternity care services by providing public funds for the services of certified midwives working autonomously, the Australian case provides a number of points of contrast. Australia’s universal health care system, also known as Medicare, has been in place since 1984. Australia’s medical practitioners are, for the most part, privately or self-employed and are able to set their own fees without government restriction. Medicare provides a fixed subsidy for different types of medical services and procedures, and patients are responsible for paying any charges levied by providers above this subsidy out of their own pockets. In the case of obstetrician led care, these charges can be large, as discussed below (Van Gool, 2009).

Another distinctive feature of the Australian health care system is its parallel private health insurance sector, resulting in a two-tiered health care system, with many of the associated problems of inefficiency and inequity (Gray, 1998). In maternity care, the private sector provides an important alternative to publicly available care, with more than one third of Australian women giving birth in private hospitals under the care of a private obstetrician

(Department of Health and Aging, 2008; Laws, Abeywardana, Walker, & Sullivan, 2007; Segal, 2004).

Private health insurance declined significantly following the introduction of Medicare in Australia (Colombo & Tapay, 2003, pp. 9–10). From 1996, various measures were taken by the conservative-leaning government to arrest and reverse this trend. These policies, and their impact on medical dominance and the provision of maternity care are the main focus of our analysis.

Measures to boost private health insurance (PHI) included a substantial subsidy in the form of a non-means tested, 30 percent rebate to residents on the purchase of PHI (Duckett, 2005a; Hurley, Vaithianathan, Crossley, & Cobb-Clark, 2002), a tax rebate for residents who bought PHI, and a range of financial penalties on those who did not take out PHI (Butler, 2002). As a result, membership of PHI rose substantially, from 30.1 percent in 1998 to 43 percent in 2000, with the level remaining steady since then. (Hurley et al., 2002, p. 8; Walker, Percival, Thurecht, & Pearse, 2005; Australian Institute of Health and Welfare, 2008).

The policies to boost PHI membership have undermined the efficiency and equity of the Australian health care system (Segal, 2004), and have not reduced waiting lists in public hospitals (Duckett, 2005b). Rather, they have provided substantial public subsidies to the wealthiest quintile of Australians, the group most likely to purchase PHI, while the impact of the reforms for the poorest 40 percent has been minimal (Walker et al., 2005). Hence, the reforms have done little to improve accessibility or equity in health care. The reforms have increased access to obstetricians in private practice, but primarily for high-income women. As mentioned earlier, the out of pocket (OOP) fees for private obstetric services can be substantial, and Australia has one of the highest rates of per-capita out of pocket expenditures (Van Gool, Savage, Buchmeuller, Haas, & Anderson, 2006, 2009b).

The government's response to the increasing rate of OOP payments was the introduction in 2004 of a suite of policies collectively known as *Medicare Plus*. Of particular relevance is the 'Extended Medicare Safety Net' (EMSN), which limits consumers' out of pocket expenses (currently set at \$1000 Australian dollars [AUD], or half that for low-income earners) in a calendar year. While the EMSN policy was originally designed to provide a safety net against catastrophic medical expenses, the policy's outcomes have been most substantial in maternity and reproductive care (Van Gool et al., 2006, 2009b). Following negotiations between medical organizations and the government, the EMSN was introduced in tandem with a new Medicare item for the planning and management of a pregnancy, hence making these services subject to the EMSN 'safety net' provisions (Glasson, 2004). As a consequence, obstetricians in private practice have been able to substantially increase their charges for the management of pregnancy: between 2006 and 2007 alone, the average fees for the planning and management of a pregnancy rose 16.2 percent, and Medicare payouts for obstetric services increased by 100 percent in the first three years of the scheme (Dunlevy, 2007, p. 1). The increased charges have been absorbed by the public purse. By 2007, safety net payments for obstetric services cost \$98.6 million AUD, making up 31 percent of total safety net expenditures (Department of Health and Aging, 2008), and

accounting for the single largest category of safety net payment. Furthermore, safety net payments have been shown to be larger in areas with relatively high median family income and lower health care needs (Van Gool et al., 2007), revealing important regional and socio-economic inequities in the scheme.

In a two-tiered health care system such as Australia's, the parallel private sector must offer advantages over the public sector in order to maintain viability (Gray, 1998, p. 910). Having PHI allows women the choice of private obstetrician, generally offers continuity of carer throughout pregnancy and childbirth, longer post-partum hospital stay if desired and often superior hospital accommodation in a private room. However, current health policy in Australia makes access to these advantages inequitable; instead, policy channels public funds to private obstetric services (Van Gool et al., 2006, p. 11), perpetuates the dominance of medicine and decreases the efficiency of the maternity sector by utilizing highly trained obstetricians as primary birth attendants for women regardless of their obstetric risk.

Australian women giving birth in the public health care system have fewer opportunities for choice of maternity care provider and little possibility of receiving continuity of care during the childbearing period. A review of maternity services conducted in Australia in 2008 highlighted the limited choices available to Australian women in relation to pregnancy and birthing care; to the extent that such choices exist, they are typically limited to low risk women who qualify for midwife-led care in a birthing unit that is part of a larger hospital (Department of Health and Aging, 2008, 2009).

While there has been a trend in Canada to publicly fund the services of certified midwives working autonomously, Australian maternity services have moved in the opposite direction and become increasingly controlled by physicians, in particular obstetricians. The only exception to this trend was a policy implemented in 2006 allowing for antenatal services in rural and remote areas to be delivered by "appropriately trained and qualified midwives, nurses and registered Aboriginal Health Workers, on behalf of medical practitioners" (Department of Health and Aging 2008, p. 9). Otherwise, Australian midwives are not eligible for reimbursement from Medicare for their services, and are not able to prescribe medications or order the relevant tests that Canadian midwives routinely do (Homer & Passant, 2005). Although Australian midwives are currently the focus of a federal government review of maternity services, there is little opportunity and negligible public financing for them to work as independent practitioners (Department of Health and Aging, 2008). Most midwives are instead employed by hospitals or medical clinics and their practice is determined by organizational imperatives or by the medical practitioners for whom they work. Despite the establishment of some midwife-led birthing centres within some hospitals, these developments have been relatively small in scale and sometimes tenuous.

Unlike their Canadian counterparts, who attend a substantial, albeit decreasing, proportion of births (Canadian Institute for Health Information, 2007), general practitioners play a relatively small and decreasing role in the provision of obstetric services in Australia (Weaver, Clark, & Vernon, 2005). Instead, obstetricians, especially those in private practices, are playing an increasing role in the provision of maternity care. Within the

maternity workforce, obstetricians have been the main beneficiaries of government policies promoting PHI. Between 1998 and 2003 the numbers of specialists qualified in obstetrics and gynecology grew by 10.6 percent (Australian Medical Workforce Advisory Committee, 2004). This growth defied earlier predictions of a projected decline of this medical specialty, based on expected retirements, and unattractive features of the specialty, such as long and unpredictable working hours and the comparatively high cost of medical indemnity (Weaver et al., 2005, p. 436; MacLennan & Spencer, 2002). In addition to this growth in absolute numbers of obstetricians, their ratio to women over the age of 15 years has increased (Australian Medical Workforce Advisory Committee, 2004). Of this workforce, the most common practice type is solo private, with an additional one-fifth working in a combination of solo private practice and public hospital work. Only 11 percent of all obstetricians work solely in the public system (Australian Medical Workforce Advisory Committee, 2004, pp. 43–46).

In sum, the current situation in Australia, with government advocacy for PHI and little support for primary maternity health care, has cemented obstetricians' dominance and increased the medicalisation of childbirth.

Neoliberalisation and the intensification of medicalisation

The data presented above show that recent neoliberal reforms undertaken by Canadian and Australian governments have not substantially altered the historically hegemonic role medicine has played in maternity care provision. In fact, available evidence suggests that increased medicalisation of pregnancy and childbirth has taken place (Conrad & Leiter, 2004; Van Teijlingen, 2005).

While Canadian family physicians are still the most common providers of prenatal care and the primary attendants at childbirth, their portion of service provision has declined over the decades. In addition, they are less likely to deliver multiple births or perform caesarean sections. Instead, more costly obstetricians, the vast majority who work in urban areas, are increasingly working as primary care attendants to birthing women (Table 1).

These various changes in maternity human resources have resulted in increased medicalisation of childbirth, despite the reintroduction of midwifery in the recent period. The proportion of women who delivered by caesarean section, for example, increased from approximately 5% to nearly 20% in Canada between the late 1960s and the early 1980s. The caesarean delivery rate decreased from 18.2% of deliveries in 1991–1992 to 17.5% in 1994–1995, and then increased steadily to 21.2% in 2000–2001 (Table 2), while recent data show the rate has increased further to 26.3% in 2005–2006.

Caesarean rates are not uniform across social groups and geographical areas. While there is a clear social gradient in caesarean rates – i.e., controlling for age, rates are significantly higher for women in low-income neighbourhoods than women in high-income neighbourhoods (Leeb, Baibergenova, Wen, Webster, & Zelmer, 2005), caesarean rates also vary among the country's provinces and territories (in 2000–2001 from a low of 8.1% in Nunavut to a high of 25.8% in New Brunswick) and even among health authorities in the same province (Canadian Perinatal Surveillance System, 2003). At the same time, maternal

hospital readmission rates after a caesarean have also been increasing, as has the national epidural rate.

These findings point to the continued medicalisation of labour and delivery. A recent cross-national study conducted by the Public Health Agency of Canada (PHAC) (2009) polling women regarding their childbearing period also supports this thesis. Despite the lack of evidence for certain medical interventions preceding birth (such as the practice of shaving a woman's pubic hair or giving her an enema), of the Canadian women surveyed 19% reported being shaved and 5% reported receiving an enema prior to birth, even though most Canadian hospitals have a policy not to adhere to such practices (PHAC, 2009 p. 12). Moreover, 21% of women surveyed received an episiotomy (PHAC, 2009, p. 13).

Australian women who gave birth in private hospitals were 50% more likely to undergo caesarean section (Van Gool, 2009), and had higher rates of forceps deliveries, vacuum extractions, and C-sections (Laws et al., 2007, p. 39). Comparison of the patterns of intervention in the two countries, shown in Table 2 reveal remarkably similar maternal outcomes for the Canadian and Australian public sectors, and a striking difference in maternity outcomes for Australian women in the private sector.

The strong association between private health status in Australia and the likelihood of a C-section cannot be explained by differences in risk profiles or birthing complications attributable to the women (Roberts, Tracy, & Peat, 2000; Shorten & Shorten, 2004). Multivariate studies demonstrate that the rise in PHI status is associated with a rise in the likelihood of an operative delivery in private hospitals. An increase in private hospital births occurred from 2000, when the full impact of changes to PHI incentives took effect. Additionally, there was a 61 percent increase in elective C-section rates for primiparous women in private hospitals between 1997 and 2001, compared with a 27 percent increase for primiparous women in public hospitals. In other words, the likelihood of an operative delivery was 2.25 times greater for primiparous women in private hospitals than those in public hospitals (Shorten & Shorten, 2004, p. 33). Furthermore, "[a]mong low risk women, regardless of parity, private patients ha[ve] higher age adjusted rates of instrumental delivery, especially after epidural... These higher rates of intervention are not associated with improved perinatal outcomes, but are associated with increased risk for mothers" (Roberts et al., 2000, pp. 139–140).

Discussion and conclusion

As we have noted above, there is no static concept of neoliberalisation; it is a process that encompasses *variegation*; "systemic geoinstitutional differentiation—as one of its essential, enduring features" (Brenner et al., 2010, in press, p. 3). In other words, processes of neoliberalisation are dependent on a variety of factors, develop unevenly, and therefore create geoinstitutional differentiation. Neoliberalisation is thus, like globalization, a 'syndrome' that encompasses heterogeneous forms of that exist and come into being through their collision with diverse institutionalizations based on different geographical socio-political landscapes (Brenner et al., 2010). Although the basic tenets of neoliberalisation are similar in form, the content and its applications differ in time and space. Furthermore, the

path-dependency of neoliberalisation is always partial; it can be solidified in different ways within institutions but it cannot itself as a mode or concept be pinned down. It is patterned and cumulative; a 'moving map' of regulatory institutionalised practices (Harvey, 2005, p. 88).

Because the pathways of neoliberalism are dependent on location and history, it is important to examine nationally specific pathways of neoliberalisation, which are not merely sustained differently within national borders, but include pathways that allow variegated forms to move across spatial and national borders. Processes of neoliberalisation therefore, no matter how they differ, link us.

The cases of the organisation of maternity care in Canada and Australia illustrate this phenomenon. The importance of such comparative work reaches beyond the borders of maternity care and pushes the theory that neoliberalisation theorists set the stage for. This paper contributes empirically to these types of analyses by outlining the ways in which neoliberalisation path-dependency occurs in contexts that are shaped by pre-existing inequities around professional status as well as gender and other structural issues. In Canada, regulatory change has involved attempts to undermine physician professional privilege by challenging their traditional gatekeeper role in the health care division of labour (Coburn, 1993). In Australia, regulatory experimentation has focused on bolstering the private health insurance sector and decreasing the risk of catastrophic health care costs for consumers. As elaborated above, the net effect of both has boosted medical dominance over maternity care provision, despite a current review of maternity services aiming to improve choice and availability of models of care provision (Van Gool, 2009).

Moreover, the resilience of medical dominance in maternity care illustrates its structural embeddedness (Bourgeault & Mulvale, 2006), which is linked to the market-mentality of the processes of neoliberalisation. As we have outlined, Australia is a good example in which larger regulatory practices inherent to neoliberal reform lay the groundwork for the continuation of institutionalised medical dominance (Willis, 2006). State concepts of market relations contribute to commodifying labour and birth through initiatives that maintain an obstetrical monopoly over childbearing, enhancing rather than presenting alternatives to medical dominance.

This is one example of the collaborative nature of medical dominance and neoliberalisation that presents a challenge for the implementation of choice and the provision of equitable maternity care (Sandall et al., 2009). Although Canada is a different story due to the regulation of midwifery, the low rates of midwifery utilization remain a problem. Choice itself as a concept is problematic due to the uneven distribution of maternity care resources based on rural/urban and Aboriginal/non-Aboriginal divides (Benoit, Carroll et al., 2007). Further choice of maternity care provider and place of birth is not equitable across the country, while the provinces/territories lack cohesion in terms of midwifery regulation, funding and legal standing. The consequences of inequality in maternity care, and the challenges to rectifying these problems, present a difficult situation for childbearing women and their families. The importance of choice and autonomy in the birthing process is well documented, as are the consequences in terms of maternal post-partum health (Benoit,

Westfall, Treloar, Phillips, & Jansson, 2007). By fleshing out the relationship between neoliberalisation and medical dominance through comparative analyses of countries that are similar in structure, we take an important step in evaluating possible solutions to the implementation of true choice and equitable maternity care.

In conclusion, neoliberalisation is neither monolithic, nor historically inevitable; more importantly, it is not necessarily counter opposed to medical dominance. In fact, at least for our case examples, there is evidence of an elective affinity between the two, hidden beneath principles of 'choice', 'reflexivity' and 'patient charters.' This neoliberal rhetoric of consumerism provides the justification for the continuing hegemony of medicine over maternity care in Canada and Australia. It would be beneficial to investigate the recent history of medicalisation of maternity care in other high-income countries using our analytical perspective, as well as to explore counter-neoliberalizing forms of regulatory restructuring in these countries and their impact on medical hegemony.

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Table 1

Maternity care providers, population and estimated births, Canada 1996–2005.

	Primary attendants at vaginal births		
	1996	2000–2001	2005
Ob/Gyn	56%	61%	
GPs/family physicians who practice obstetrics	44%	39%	
Certified midwives	n/a	<1%	3%

Source: CIHI. 2004.

Table 2

Maternity outcomes for Canadian and Australian women by hospital sector, 2005.

Delivery method	Australian private	Australian public	Canadian
Spontaneous vaginal	44.6	63.1	60.2
C-section	40.3	27.1	26.3
Forceps	5.1	3.0	3.7
Vacuum extraction	9.7	6.4	9.8

Sources: Australia: Australian Institute of Health and Welfare, 2005; Canadian Institute for Health Information, 2007; Laws et al., 2007.