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Commentary

Commercialisation and entrepreneurialism in maternity

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ABSTRACT

Objective: against an international background, to examine the implications of private sector activity for maternity care in the United Kingdom National Health Service (UK NHS).
Background: the private sector and commercial or entrepreneurial activity in maternity services have attracted limited attention in the UK compared with, for e.g., Greece and the Irish Republic.
Method: discursive paper.
Key conclusions: despite rhetoric to the contrary, financial costs have always featured in the UK NHS. Financial payments in maternity have increased gradually. Commercial and entrepreneurial activity in maternity now includes 'entertainment ultrasound', reflecting a greater hegemonic imbalance. The commercialisation of maternity raises organisational, professional, quality-related and systematic issues, which all carry implications for the childbearing woman.
Relevance to clinical practice: the childbearing woman shoulders financial costs, whose origins and implications matter to both midwife and woman. The mixed benefits of medical investigations deserve closer attention.

Introduction

The UK NHS has long been applauded as the realisation of an admirable ideal; such idealism may be found in the high moral principles on which it is founded, particularly in its universal accessibility. In association with recent UK governmental developments and anticipated financial constraints, it is timely to consider whether these fundamentally important attributes are threatened. For the purposes of discussion, the context used is the maternity services. I question whether these principles and the objective of universal accessibility are still sought as they were in 1946, when the National Health Service Act stated that services would be 'free at the point of use' (MOH, 1946).

In this paper, I contemplate the context and then move on to developments in UK maternity care carrying financial implications. The relevant changes are those with the potential to reduce the accessibility of services because of financial costs. I recognise that these issues may assume a somewhat different significance globally (Koivusalo and Mackintosh, 2004), so I confine my discussion to UK maternity care. Analysis shows that the availability of certain NHS services appears insufficient for the demand which has developed. This demand appears to only be satisfied by the involvement of commercial, entrepreneurial or private sector activity. The term 'commercialisation' includes market relationships, health systems based on individual payments or private insurance, and investment for profit (Mackintosh, 2003: 4). 'Entrepreneurialism', however, is more narrowly focussed and applied to individuals moving towards 'a more market-based system' (van der Scheer, 2007: 52). Issues emerge relating to professionals' roles in creating markets.

Background

Origins

The UK NHS is founded on 'the principle of collective responsibility by the state for a comprehensive health service' (EOHCS, 1999: 5). The altruistic origins of the UK NHS may represent a form of social engineering. The 1940s redistributive ideals sought to ameliorate, if not correct, the massive social inequalities peculiar to the UK, unlike other western European states (de Wildt, 2008).

Although the mantra of 'free at the point of use' is recited *ad nauseam*, the NHS legislation has always carried the possibility of charging for certain services, including prescriptions and dentistry. Despite this, the Beveridge Report (1942) which presaged the NHS Act, indubitably focussed on accessibility:

> The importance of securing that suitable … treatment is available for every citizen and that recourse to it, at the earliest moment when it becomes desirable, is not delayed by any financial considerations (Beveridge, 1942, sect 433(i)).

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Similarly, the intention of the 1946 Act was to overcome the then familiar barriers, in order to facilitate universal access to health care, another lofty aim that has never actually been achieved. There are various barriers limiting access to services, most obviously, whether the service exists. The utilisation of services, though, is limited by personal factors, such as attitudes and expectations. Further, organisational barriers in the form of waiting lists/times reflect inefficient or staff-oriented services (Gulliford et al., 2002).

Although financial barriers were intended to have been obliterated by the 1946 legislation, charges for investigations such as eye tests and dental checks continued alongside prescription costs. Thus, the 'free health service' (Klein, 1995: 303) envisaged by William Beveridge in 1942 and operationalised by Aneurin Bevan in 1948 was never quite what it was purported to be (Musgrove, 2000); despite the best efforts of the 'architect' and 'midwife' of the health service, respectively, being 'free' proved unrealistic.

Recent past

Organisationally, it was the UK Conservative government's community care reforms of 1990 which brought a market orientation (Knapp et al., 2001). Such reforms have been introduced to seek to resolve health service problems facing a range of westernised countries (Docteur and Oxley, 2003). The suggested reforms constitute knee jerk responses to growing health-care demands and increasingly constrained resources. These developments, widely regarded as antithetical to the principles on which the NHS was founded, represented 'commercialisation of care' (Wistow et al., 1994). Until recently the input of independent or private sector bodies has been as partnerships which have comprised consortia to create Public Private Partnerships (PPPs) and Private Finance Initiatives (PFIs), which have raised capital investment for hospital and community projects (Talbot-Smith and Pollock, 2006; Hellowell and Pollock, 2007). At the time of writing, governmental plans for NHS reform seem to be limited to England (House of Commons, 2011). The precise nature, extent and effects of these reforms on NHS finance remain to be clarified, although it is clear that any caps on private services/provision appear to be being lifted.

A developing situation

Maternity service changes

Against this background of aspirations, claims, payments and needs, there have been surreptitious changes in UK maternity provision. The introduction of payments by users of maternity services has happened gradually, and I now trace their growth in chronological order.

Childbirth education

The first additional financial contributions were for education during pregnancy. Although the origins of childbirth education are shrouded in mists of myth, analysis of the growth of childbirth education (Nolan, 1997) shows how the breakdown of childbearing women's social networks accelerated its development. Preparing for her case study of the NCT, Kitzinger (1990) discusses its financial resources. When founded in the 1950s, the NCT relied on 'donations and hand-to-mouth fund-raising, such as selling milk bottle tops' (1990: 92). By 1968, however, this had changed to income from membership subscriptions and teachers' fees.

In the UK, Kitzinger notes, the NCT as a teaching organisation functioned independently of the NHS, and fees were a new departure. The enthusiasm for childbirth education among middle class women and accompanying payments were imported from North America; there the fervour for Lamaze and Dick-Read resulted from a reaction against more extreme forms of pain control, such as twilight sleep, whereas lay organisations had some impact on increasing the use of pain control in the early twentieth century (Beinart, 1990; Humenick, 2004).

At the time of writing the NCT subscription, covering two people living together, is approximately £36 per annum. There are, however, special rates for long term membership and reduced rates for those receiving benefits (NCT, 2010). As the NCT introduced the concept, a number of other non-NHS agencies and organisations have begun to offer services to the childbearing woman. Such services may either duplicate or supplant NHS provision and, for obvious reasons, these agencies levy fees and subscription charges.

'Pay beds'

Differing phenomena have been injudiciously linked in the single category of 'pay beds' which are familiar to many midwives. The origins of this situation relate to a compromise by Bevan when introducing the NHS.

Amenity rooms

Ideologically opposed to private medicine, Bevan opted to offer NHS 'amenity' beds to 'better-off patients' (Ryan, 1975: 167) seeking low-cost privacy. Thus, Bevan sought to curtail demand for private medicine.

New mothers in UK maternity units now share accommodation with smaller numbers of other women. Of course, some women choosing to give birth in hospital are reluctant to share accommodation with anybody, so amenity rooms are available for healthy women seeking single accommodation (Medway, 2010). Although what some amenity room occupants call a 'private room' carries kudos, the care provided is no different from that offered in the 'ordinary wards' (Ryan, 1975: 167). This is not always clear from the publicity for such accommodation (Medway, 2010). What may make the provision of amenity beds somewhat contentious, especially for staff, is the long-articulated premise that women with health problems have priority of access to single rooms. In fact Medway mentions the possibility of women without health problems facing eviction from amenity rooms should they be needed for an ill woman, stating: 'we may need to ask you to vacate the room' (2010).

Private maternity care

Although well-publicised, through the high profile childbearing of 'celebs', the reality of private maternity care is less straightforward.

Private obstetric services

The widespread availability of private obstetrics is shown through a web search using a search engine which, when limited to UK websites, produced 742 hits for the search term 'Private obstetrician'. A search using the search term 'private maternity hospital' produced a rather different result in the form of the Private Healthcare UK (2010) website stating:

> Private maternity hospitals and other services for private maternity care in the UK are relatively limited compared to the services available for private hospital surgery.

The unsurprising conclusion is that many obstetricians practise privately in NHS premises. Because obstetric services in private maternity hospitals are still a minority activity in the UK, it is necessary to look to the Republic of Ireland for a more complete