

# COUNCIL FOR EUROPEAN STUDIES

## Sixteenth International Conference

### Call for Papers

The Drake Hotel, Chicago  
March 6 – 8, 2008

Deadline: **June 1, 2007**  
Submit proposals to [ces@columbia.edu](mailto:ces@columbia.edu)

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#### NOTE:

The Committee will accept **a maximum of 2 submissions** per person.  
The draft program will be posted to the CES website on **November 5, 2007**.

**COUNCIL FOR EUROPEAN STUDIES**  
**Sixteenth International Conference**

**INDIVIDUAL PAPER PROPOSAL**

Paper Title **\_\_ The Politics of Childbirth: Divergence of Maternal Health Policies among Advanced Industrialized Countries** \_\_\_\_\_

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Abstract

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Childbirth is one of the most widely shared experiences of roughly half the world's population. Yet even among the most highly developed countries, the quality of that experience varies tremendously, with high-intervention practices becoming increasingly the rule in the US, while countries such as the Netherlands have relatively low numbers of cesareans, but high numbers of homebirths with excellent results. A discourse of medical rationality would have us expect that wealthy countries provide the best care available for whatever health needs present themselves, including the needs of women giving birth. Yet countries clearly differ in what they consider the "best" care. Why do otherwise similar countries diverge in their approaches to childbirth and maternal health? This paper presents research design and preliminary findings for a new multi-country investigation into policy divergence in maternal health policies. I investigate three hypotheses:

H0: Medical rationality dictates the choice of obstetric techniques in advanced capitalist countries of comparable wealth. If this is correct, then we would expect medical risk factors such as drug addiction, maternal age, multiple births, and preterm labor to explain most of the variance in childbirth practices among high-income countries.

H1: Social factors such as poverty, minority status, access to health insurance and prenatal care, and education, are likely to determine the experiences of women undergoing childbirth. The logic of this hypothesis is that poverty etc. mediates access to the best health care available. It does not question medical "rationality" itself.

H2: Political-economic institutions shape the incentive structures within which actors (health providers, women, and policy-makers) approach childbirth. Medical "rationality" itself is interpreted differently depending on the institutional context within which actors find themselves.

H2.1: Specifically: Medical malpractice systems with high damage awards create incentives for "defensive medicine," i.e. the tendency to employ high-intervention techniques preemptively.

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H2.2: Certain systems of health care financing make high-intervention practices profitable for physicians and hospitals.

H2.3: Systems of accreditation and certification of health practitioners, notably midwives, affect the availability of options outside of standard obstetrician-attended hospital births.

H2.4: The presence of a women's health movement and/or advocacy groups affects legislative change over time and thus the availability of options outside of standard obstetrician-attended hospital births.

This research project draws on public health (for data on obstetric practices, demographic data, information on risks associated with specific approaches, etc.); sociology (for linking demographics to health care access); and political science (for examining institutional factors such as malpractice law and health care financing; and for investigating the impact of societal interests on policy outcomes). Childbirth tends to be viewed as apolitical and technocratic. This project challenges this view by investigating the glaring differences in childbirth practices among similarly wealthy countries.

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