

# Inequalities in health care provision: the relationship between contemporary policy and contemporary practice in maternity services in England

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Submitted for publication 22 December 2000

Accepted for publication 28 November 2001

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HART A. & LOCKEY R. (2002) *Journal of Advanced Nursing* 37(5), 485–493

## **Inequalities in health care provision: the relationship between contemporary policy and contemporary practice in maternity services in England**

**Aim.** The project *Addressing Inequalities in Health: new directions in midwifery education and practice* (Hart *et al.* 2001) was commissioned by the English National Board for Nursing, Midwifery and Health Visiting (ENB). Here, we draw on those research findings to consider current midwifery policy and practice in England.

**Background.** Little guidance on providing equality of care exists for midwives. The Code of Conduct [United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1992] makes no specific requirement for midwives to address issues of inequalities of health in their practice. Recent policy documents emphasize the need to work towards reducing inequalities and to target practice to ‘disadvantaged clients’ without giving guidelines on how to identify and care for target groups.

**Methods.** In-depth studies of midwifery education and service provision were conducted in three very different parts of England. Three months of fieldwork were undertaken at each site, comprising a series of interviews with midwifery educators, managers, students, midwives and service users. Focus groups were also held and observation of classroom sessions and midwifery practice undertaken.

**Findings.** A lack of clear and specific strategies concerning inequalities in health was evident at managerial level. Patchy knowledge of current policy was also evident amongst practising midwives. Specific projects with disadvantaged clients usually resulted from a particular midwife’s personal interest or evident local need. All midwives emphasized the importance of ‘equality of care’. How this was operationalized varied, and ‘individualized’ or ‘woman-centred’ care was assumed to encompass the concept. In the few examples where care was systematically targeted in accordance with policy directives, the midwife’s public health role was increased.

**Conclusion.** In the absence of a co-ordinated strategic vision driven by managers, practitioners find difficulty in prioritizing care and targeting resources to disadvantaged clients in line with policy directives. Tensions between policy and practice in the care of ‘disadvantaged’ women clearly exist. Successful implementation of policy

at practice level needs: commitment from managers; clarity of purpose in documentation; and provision of specific targets for practitioners. However, the latter should remain flexible enough for the delivery of care to be appropriate and sensitive to individual needs.

**Keywords:** policy, midwifery, care, changing childbirth, inequalities, disadvantaged clients, individualized care, women-centred, roles, professional friend, user-led services

## Introduction

A proliferation of recent policy mandates from British central government have attempted to steer midwives and other health professionals towards focusing their work on disadvantaged clients, and thus on tackling inequalities [Department of Health (DOH) 1999, 2000]. These policy directives appear to come as a result of a genuine commitment on the part of the current government to address health inequalities. We suggest that at policy level there is a clear imperative to target 'disadvantaged clients'. However, this is matched by vagueness within the documents about who those clients are, and what practitioners should actually be doing in relation to them.

In this paper we draw on some of the data from a research project we recently undertook to illustrate our ideas concerning this potential mismatch between policy visions and actual practice. The main research report was published by the English National Board for Nursing, Midwifery and Health Visiting (Hart *et al.* 2001). In this paper, we do not make any claims for the generalizability of the data we have used to illustrate our argument. The degree to which the ideas we develop are relevant more generally within the midwifery (and other primary health) context(s) is part of a debate we hope to stimulate.

Thus we suggest that in the contexts in which we conducted our research, policy visions do not always follow through clearly and directly to the operational level (Hart *et al.* 2001). We also argue that there is not always a clear consensus at the operational level as to who 'disadvantaged clients' are. Similarly midwives in our research were unsure as to precisely what they should be doing in relation to clients who they identified as disadvantaged. Thus, which clients received more care from midwives under which circumstances appeared to be inconsistent, depending on local service development, the interests of individual midwives, and very selective responses to national policies. Further, as we shall show below, different midwives worked with very different concepts of disadvantage, which then impacted on how they organized care in their caseload. Another important

issue is that midwifery clients defined by practitioners as disadvantaged may not see themselves in this light, and may not be the willing recipients of targeted input. This is a complex issue which is beyond the scope of this paper and we deal with it more specifically elsewhere (Hart *et al.* 2001).

Many other authors in the midwifery field have written about care for disadvantaged service users. In line with midwifery's philosophy of 'individualized care', most of this literature concentrates on individual accounts, or on practical interventions with specific groups (for example, Davies 1992, 1997, Kargar & Hunt 1997). Very few of the discussions take on board the broader conceptual and/or socio-political issues prominent in sociological considerations of issues of inequality and disadvantage (but see Salmon & Powell 1998). For a critical review of the concept of disadvantage and its application in the midwifery literature see Hart *et al.* (2001).

After setting the scene in relation to policy directives prominent during our research period, we then go on to explore issues raised within the research context from which our data was drawn. We discuss practising midwives' understandings of policy frameworks and then explore their perceptions of 'the midwife's role' in relation to disadvantaged clients.

## Midwifery, inequalities and contemporary policy frameworks in England

Midwives in England work in accordance with a professional code of conduct laid out by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1992). At present, the Code of Conduct makes no specific requirement for nurses, midwives and health visitors to address issues of inequalities in health in their practice. However, a related requirement (UKCC 1992), states that:

As a registered nurse, midwife or health visitor you are personally accountable for your practice and, in the exercise of your professional accountability, must...recognize and respect the uniqueness and dignity of each patient and client, and respond to their need for care,

irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor (UKCC 1992).

Thus, the UKCC falls short of making reference to issues of inequalities and/or antidiscriminatory practice. Instead, nurses and midwives are required to treat individual patients and clients with respect, 'irrespective of' their ethnic origin, etc. suggesting that these differences are almost to be ignored in shaping their 'need for care'. This 'liberal' approach to inequality, reflected in midwifery's 'individualized care' philosophy, is often very ambiguous about difference and equality issues. At best, cultural and other 'differences' are recognized and respected. Rarely are they understood in relation to 'disadvantage' in a more overtly structural and political sense as in, for example, social work policy and practice (Thompson 1998).

This concept of 'individualized' care, along with the notion of 'woman-centred' care has become a dominant feature of British midwifery. Central to some of our concerns about the provision of care to individual 'disadvantaged' women are discussions about the widely influential conservative government's policy directives contained in the report *Changing Childbirth* (DoH 1993). This document was seen to be the first serious attempt by government to formalize the midwife's role as the lead professional in women's care and to improve continuity of care(r) for women. One of its key 'success indicators' was that at least 75% of women should know the person who cares for them during their delivery. However, as some commentators have argued, the laudable visionary sentiments in the document were not matched by a commitment by central government to commit the financial resources necessary to improve service provision (Hart *et al.* 1999).

It is interesting to note that most practising midwives in our study knew much more about this particular policy initiative than they did about previous and subsequent related policies. This may well have been because of its very specific focus on midwifery, although it should be noted that many other policy documents have had much to say about maternity care and midwifery practice (for example House of Commons 1992).

The recommendations of *Changing Childbirth* were taken very seriously by stakeholders at all levels in local National Health Service (NHS) trusts and attempts were made to implement them. However, whilst *Changing Childbirth* did much to further the pursuit of 'woman-centred' and 'individualized care', some commentators argue that it failed to address the needs of 'disadvantaged' women (Tyler 1994). Both the Winterton Report (House of Commons 1992) and

*Changing Childbirth* (DoH 1993) have been criticized for concentrating on the views of affluent, articulate and what might be thought of as 'healthcare-savvy' users of the service. Some argue that these users have little insight into the needs of those living, for example, with a disability, in poverty or on the margins of society (Cardale 1992, Hart 1997). However, the Winterton Report (House of Commons 1992) criticized the Departments of Health and Social Security for not providing accurate information on benefits, and reported on difficulties of eating healthily on the money provided to disadvantaged women (Davies 1992). Further, defenders of *Changing Childbirth* point to dedicated projects which focused on disadvantaged clients. Nevertheless, it is clearly the case that *Changing Childbirth* missed an opportunity to include an indicator of improvements in maternity services that directly and specifically related to the needs of 'disadvantaged' service users.

Since then, there have been many policy initiatives that have focused specifically on inequality. However, they have not enjoyed nearly as much prominence within midwifery. For example, in 1998 the influential Independent Inquiry into Inequalities in Health (the Acheson Report), (DoH 1998b) made a key recommendation which had the potential to be of considerable importance to midwifery:

We recommend a high priority is given to policies aimed at improving health and reducing health inequalities in women of childbearing age, expectant mothers and young children. (Department of Health 1998b, p. 1)

Following this report, the consultation document *Supporting Families* (Home Office 1998) considered the needs of expectant women and those with young children to be of utmost importance, although the emphasis placed on tackling the effects of poverty in documents such as *Our Healthier Nation* (DoH 1998a) fell short of providing specific targets for maternal and neonatal health. Particularly relevant here is the exclusion of a target on the incidence of low birth-weight babies.

The more recent document *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting contribution to health and healthcare* (DoH 1999) gives midwives a central role in health promotion for 'disadvantaged' women. This document focuses more on inequalities than *Changing Childbirth* in that it argues that care should be targeted to those who are disadvantaged. However, there is no definition of the concept of disadvantage in the document which, as we have suggested elsewhere, is a complex, contested concept (Hart *et al.* 2001). Furthermore, the document is silent on the issue of providing increased financial resources with which to develop services. What it fails to point out is that this will

inevitably result in some others having less choice and input from health care professionals. There is, then, a health rationing discourse implicit in the document, but nowhere is this acknowledged. Further, there is no discussion of the notion of promoting 'equality of care', let alone a consideration of the complexities of what that might mean in practice (Thompson 1998).

*Making a Difference* (DoH 1999) explains the Government's strategic intentions for nursing, midwifery and health visiting. It regards these professions as having a key role in plans to modernize the NHS and to improve the public's health. One of the main thrusts of *Making a Difference* is that nurses, midwives and health visitors should be reaching out and working within the wider community, and across organizational boundaries, in order to provide 'seamless care'. *Making a Difference* also refers to the proliferation of multidisciplinary projects funded by central government which are designed to improve the health status of clients in areas of high socio-economic deprivation.

*Making a Difference* highlights, and we argue, idealizes the relationship between midwives and clients as one which provides a 'window of opportunity' for broader health promotion work to be undertaken with clients:

Building on the excellent partnership they establish with women in their care, midwives are well-placed to play a bigger role in health promotion...There is scope for midwives to extend their contact with women after birth, to use their relationship and knowledge of the individual to improve the detection and referral of those mothers suffering from postnatal depression. (DoH 1999, p. 67)

Whilst many midwives do develop close, supportive and relatively long-term relationships with their clients, it should be acknowledged that, in documents such as *Making a Difference* (DoH 1999), this is taken for granted as being always the case. The issue of which midwives develop close relationships with which clients in which circumstances is not explored. The theme of the midwife as 'professional friend' is one that has enjoyed some prominence in the midwifery literature (Fraser *et al.* 1998, Pairman 2000), and it could certainly be argued that it is a concept that many midwifery theorists, educators and practitioners espouse and aspire to.

In reality, relationships between clients and midwives are not always of this kind (Hunt & Symonds 1995, Neile 1997). In our recent research we found strong evidence of this with clients who experienced constellations of disadvantage (Hart *et al.* 2001). Here, the midwife often had a role of detection and referral, particularly in relation to child protection concerns, and this did not always sit comfortably with the concept of the 'professional friend' for either midwife or

service user. A further consideration here is that the promotion of the 'professional friend' ideal in policy and practice may detract from exploration of other models of midwifery care, which place less emphasis on building relationships between professionals and clients, and more on building peer relationships between women. For example, some models of community health and social care emphasize building on 'social inclusion' and a sense of peer community (Wilkinson 1996). However such models are only just beginning to be applied in the midwifery context (Leap 1996, Sandall 2000, personal communication).

Towards the end of our research project, following *Making a Difference*, *The NHS Plan* (DoH 2000) specifically mentions that midwives will develop their role in public health and family wellbeing. Furthermore, this document is much more specific than previous ones, and gives outcome targets for service delivery within specific timescales, although it does not mention any midwifery-specific targets:

The NHS plan will bring health improvements across the board for patients but for the first time there will also be a national inequalities target. (DoH 2000, p. 5)

Whilst this document was not publicly available during the course of our research, we believe it may have considerable significance for the future of midwifery practice and thus we return to it later.

The government vision of an enhanced role for midwives in addressing inequalities is shared by the Royal College of Midwives (RCM). The recent document *Vision 2000* (RCM 2000) is very clear that the 'unique' role of the 'Midwife 2000' should have a strong public health emphasis:

She (the midwife) will...work as a public health practitioner, promoting community wellbeing and reducing inequalities in health through health promotion, health profiling, tailored service provision, and working in creative partnerships across professional and sectoral divides. (RCM 2000, p. 14)

*Vision 2000* goes on to say that 'midwives themselves will need to re-interpret their role in order to meet the changing needs of mothers and infants' (RCM 2000, p. 14). Thus in keeping with the current political climate, there is an emphasis at a policy level on the potential for change in the midwife's role. There is, however, lack of clarity about what this might mean for midwives. In our study, practitioners were often uncertain as to what exactly they should be doing and what the limits of their role were.

In all the recent policy documents discussed it is clear that there is an emphasis on the need for midwives to work towards reducing inequalities and to target their practice to 'disadvantaged' clients. There is brief mention of some

specific client groups, such as those living on low incomes, teenagers, women who are the victims of domestic violence, and ethnic minorities. However, the content of the policy documents bypasses the complex conceptual debate about which individuals count as being disadvantaged and in which context. We have explored this debate and its relevance to midwifery practice in some detail elsewhere (Hart *et al.* 2001). Thus, there is a tendency for policy documents to take for granted those who health care professionals should target as 'disadvantaged'. We argue that at the level of midwifery practice these issues are by no means clear and that there are widespread discrepancies as to which clients are perceived to be 'disadvantaged' and in which contexts.

## The research project

### Methods

The findings we explore below come from our in-depth study of midwifery education and practice, commissioned by the ENB, in relation to the needs of disadvantaged clients and the role of the midwife in meeting them (Hart *et al.* 2001). The study began with a national survey of pre- and postregistration midwifery education relating to inequalities and disadvantage. This was followed by in-depth studies of midwifery education and practice in three very different parts of England. Case Site A had relatively low levels of social and economic deprivation and a clustered community of ethnic minorities. Case Site B had relatively high levels of social and economic deprivation and Case Site C had high levels of social and economic deprivation and a large, diverse ethnic minority population. Three months of fieldwork were undertaken at each site. This comprised a series of interviews with midwifery educators, managers, students, midwives, bilingual health advocates and service users. In addition focus groups were carried out, as well as observation of midwifery education and practice. In total, 254 hours of data were collected. Ethical clearance was obtained for the research in each of the case sites.

### Methodology

Our methodological approach drew broadly on grounded theory, with its emphasis on developing interpretations from the data, rather than testing any prior hypothesis (Glaser & Strauss 1965). However, it should be noted that in contrast to research that is wholly embedded within the grounded theory paradigm, we had carried out a detailed literature search prior to data collection. Thus we were conversant with many of the different ways in which issues of disadvantage were addressed in the fields of midwifery and the social sciences.

Further, some members of the research team already had wide knowledge of debates in the field of inequalities in health. Thus, whilst both the questionnaire and interview formats and observations in the case sites were influenced by our prior knowledge and understandings, we made a conscious effort to allow informants' own perceptions to emerge.

### Data analysis

The interview data were fully transcribed and anonymized, and as a consequence, any client or professional names that occur in this paper are fictitious. All data were categorized and coded thematically. The researchers then 'progressively focused' on areas that illustrated key issues relating to midwifery education and practice in the context of work with disadvantaged clients (Parlett & Dearden 1981).

Our research gave us an indication of the empirical reality of providing midwifery care to service users from a variety of socio-economic and ethnic backgrounds. It also shows how well midwives are prepared through the education process to meet the needs of these different service users. In the following sections we concentrate on our findings about practising midwives' perceptions of their role in relation to disadvantaged clients. We also consider the way in which the empirical reality of midwifery service provision relates to policy initiatives. Consideration of these issues as they relate to the educational context is beyond the scope of this paper.

### Translating policy into practice

Our research shows that there was patchy knowledge amongst practising midwives of the broader policy agenda on inequalities in health and its vision regarding the changing role of the midwife. More surprising was the fairly common lack of knowledge of policy mandates at managerial level, which meant that managers did not ground their discussions of local service provision to 'disadvantaged' clients in the wider policy framework. With a few exceptions, it seemed that managers did not have clear and specific strategies in relation to inequalities in health. Interviewees often demonstrated general vagueness about this topic. For example, when one manager was asked if she had read anything in the area of inequalities in health, she told the interviewer that she could not remember anything specific. In contrast, one manager was able to demonstrate a broad awareness of government policies on inequalities, and went on to critique them. However, it should be acknowledged that this was an atypical example.

It should not be assumed then, that dissemination of policy visions functioned according to a top-down approach in which midwifery managers filtered information and directives

through to front-line staff. This is evidenced by the fact that in one of the case sites there were some practising midwives who demonstrated greater knowledge of policy issues than their managers, and who talked in a concrete way about their role as midwives in addressing inequalities. For example, practising midwife Clarissa emphasized a need to work at a more strategic level in relation to disadvantage:

I suppose we should be working in a more organized way to try and change things as well as make a difference individually. (Clarissa, community midwife)

However, without strong leadership and awareness of inequalities on the part of midwifery managers, the good intentions of practising midwives such as Clarissa are unlikely to be translated easily into practice.

Midwives often undertook projects and/or work with particular clients, largely as a result of their own personal interest and commitment. Rarely were midwifery roles developed for specific 'disadvantaged' clients in response to a strategic overview of service provision initiated by managers. It was also very clear that in some cases, provision for clients defined as disadvantaged was based on what was perceived to be important locally, although we found no evidence of comprehensive needs assessments having been carried out in any of the areas we studied.

Thus service provision was often initiated either in response to a midwife's own personal interest, or as a result of perceived local need. For example, in the first two case sites there was particular emphasis on dedicated service provision for younger mothers. In both sites this consisted of an informal weekly ante-natal 'club', and in one of these 'clubs' midwives worked jointly with welfare rights advisors and health visitors.

In one site, this dedicated provision was introduced explicitly because of a higher than average number of younger mothers and the initiative had been established prior to the London-based Social Exclusion Unit's (1999) influential report on teenage pregnancy. In another, it came about as a result of one midwife's long-term personal commitment to this client group. In the third case site, this client group was not perceived to be a high priority for targeted midwifery resources. When we reflected with midwives from this case site on the difference between their approach to service provision for younger mothers and the approaches taken in other case sites, they informed us that other providers (for example, social services) made such provision in their local area. A further reason for their lack of specific attention to younger mothers was the overwhelming challenge to service provision represented by the high proportion of non-English speaking ethnic minority clients in this area. Thus the

specialist input was concentrated on providing a basic level of bilingual advocacy services, which were seen to be the priority in specialist provision here.

### Promoting equality of care in practice

We stated above that some midwives and their managers were unaware of national policy developments in relation to service provision for disadvantaged clients. However, as we have shown in the previous discussion this did not mean that they eschewed attempting to bring about equality of care. With few exceptions, all midwives emphasized the importance of aiming for equality of care. However, visions as to how this was achievable in practice varied. For example, Charlotte, a community midwife in case site C had some strong views on midwives' ability to deliver 'equality of care':

Well, this is where all the rhetoric comes in, doesn't it? Very nice but not deliverable. Not even in any sort of shape or form at the moment.

Other midwives were less questioning and critical of the possibility of bringing about equality of care, and appeared to believe that it was achievable through giving 'individualized' or 'woman-centred' care to all women. In many cases, these terms were used in a taken for granted way, and some midwives clearly felt that they were providing equality of care because they believed themselves to be operationalizing these approaches across the board.

However, most midwives were able to articulate the notion that equality of care might mean differentiation. For example:

It doesn't mean the same care. It means best quality care to each individual woman depending on her needs. It might mean many different numbers of hours, for instance, for different women. (Clarissa, community midwife)

Nevertheless, this rarely resulted in systematic targeted care addressing disadvantaged clients' needs in the spirit of the more recent policy directives. More common was a vague commitment from individual midwives to target care in a manner that they deemed to be appropriate. As Jackie suggested:

I do help the ones I feel need helping. (community midwife)

It could be argued that this individualized approach to client care is an example of a midwife exercising professional judgement in the light of client need. However, as we discovered, many practising midwives and their managers had a limited understanding of their role in relation to broader inequalities issues. Further, we have evidence to suggest that, in the midwifery contexts in which we undertook our research, midwives had only rarely reflected on their

own values and prejudices in relation to client care. Thus the 'ones' Jackie felt needed helping were selected as a result of her very personal views on 'need' rather than in response to a co-ordinated framework for targeting care in the local midwifery context.

A further example of the primacy given to personal interpretations of who may be disadvantaged is exemplified in two interviews with midwifery managers. Both expressed concern that targeting resources to disadvantaged clients would take away resources from 'Mrs Average'. As one put it:

...My concern is that we might take away from people who actually still have a need as well. So I think it is getting the balance...it is the mums in [affluent area] that sometimes have more postnatal depression. They aren't actually surrounded by a nuclear family...Partners work long hours. So they have a need. (Peggy, community midwifery manager)

Thus it was the case that different midwives had different perceptions about whom they perceived as disadvantaged, and in the above case it could be argued that these two managers were advocating for resources for women who were remarkably similar to themselves.

However, it was not only midwives who had very different views about who should be targeted. Our interviews with 'disadvantaged' services users, referred to us by midwives, demonstrated that they too had very different ideas about these issues. For example, we found that some had very low expectations and demanded little of midwives. Such clients did not see themselves as disadvantaged, despite a very low income and poor housing conditions. Relevant issues here for practice include midwives using their professional knowledge to make decisions about targeting of care to clients who do not verbalize their needs, but who clearly could benefit from input, juxtaposed with a client's autonomy and rights not to receive care that they do not want. These latter points are central to the debate concerning the concept of 'disadvantage' and how to operationalize it in the midwifery context (Hart *et al.* 2001).

### Barriers to targeting care

As well as the issue of midwife perception of need and client perception of whether or not they were disadvantaged and therefore in need of extra care, other factors impacted on midwives' abilities to target care to 'disadvantaged clients'. Putting aside the issues of limited resources and understaffing, the ideology of 'woman-centred' and 'individualized care' in the midwifery context may go some way to militate against midwives targeting care in line with government

directives. These philosophies implicitly deny issues of rationing and prioritization of resources. This often results in articulate, educated women with high expectations receiving more midwifery resources than others. In our study, there was a clear sense that such women expected, and therefore often received, more input from midwives than did less 'demanding' clients. Such expectations were matched by midwives willingly implementing individualized care with 'health care savvy' clients, that is giving them more resources and more midwifery time than they gave to others:

They will have like an A4 page of questions waiting for the midwife. So the midwife can't just go in and say, 'Ah, that rash is nothing'. She has to explain what it is called, how long it will last, what colour it will turn, what cream to rub on, what cream to rub off, blah, blah, blah. (Claire, community midwife)

Thus it was clear from our research that, in the absence of a co-ordinated strategic vision driven through by managers, many practitioners would find it hard to prioritize care and target resources to disadvantaged clients in line with policy directives. The need for practitioners and policy-makers to establish base-line criteria regarding what constitutes disadvantage is an issue here. Without such base-line data there is a danger that care will always be allocated according to very local criteria, or according to the vagaries of individual midwives or managers.

However, it should also be acknowledged that an absence of strategic direction was not always the case, and there were some examples of midwives and their managers targeting care in accordance with policy directives. This included recognition of the potential for a public health role as advocated in documents such as *Vision 2000* (RCM 2000) and *The NHS Plan* (DoH 2000). Thus some midwife interviewees' interpretations of policy were for midwives to play a much broader health promotion role, sometimes accompanied by targeting disadvantaged clients.

However, these broader public health roles are not themselves without problems. For example, one midwife felt very clearly that, in line with the thrust of contemporary policy, her role had changed towards what she described as 'a more general health advocate role for disadvantaged clients'. Rather than wholly endorsing this new policy vision, she was ambivalent about the changes:

...I feel fairly de-skilled as a midwife...because we have had to move away, or I have moved away, from our role as a midwife and being more of the health advocate, I think, for the family. The very in-depth discussions that you would have relating to antenatal screening or their perception of their pregnancy just doesn't happen. Instead it's

'Why is your 6-year-old not at school?', 'Are they up to date with their vaccinations?' 'Are you fasting at the moment?' You know, the sorts of things when I qualified as a midwife I wouldn't consider relevant at that point. (Charlotte, community midwife)

Other midwives we interviewed also appeared to have a broader role in relation to disadvantaged clients, although unlike Charlotte, they did not relate these roles to policy changes. It is clear then that many midwives (whether or not they realize it) already go some way towards fulfilling the government's vision of the 'public health practitioner'. However, whether this is an appropriate way in which the role of the midwife should be developed is worthy of further consideration.

### Temporal considerations

One issue, which has not been explored in the policy documents we outlined at the beginning of this paper, is whether or not it is effective for midwives with their relatively short-term involvement in clients' lives, to be involved in addressing what are very long-term problems. Drawing on our research findings, we found that midwives who worked in areas of high socio-economic deprivation were especially anxious to emphasize the need for boundaries around their role in relation to taking responsibility for addressing inequalities, and some had difficulties with the notion of broadening their role. These midwives felt a particular need to refer clients to other services, rather than to assume a broader health advocate role, and were largely 'fire-fighting' in order to provide a basic level of midwifery care.

### Conclusion: developing midwifery practice in relation to disadvantaged clients

This paper began by exploring the content of recent British government policy documents relevant to midwifery practice. We showed how policy has attempted to steer midwives towards a broader health promotion role, with particular emphasis on working with 'disadvantaged' clients. We went on to explore how this targeting does not sit easily with the operationalization of individualized or woman-centred care currently prevalent in midwifery. We then explored the impact of current policy initiatives on midwifery practice in the areas in which we conducted our research. Our data suggest that managers and midwives often had patchy knowledge of policy directives and that understandings of which clients were 'disadvantaged' were inconsistent and often very personal to individual midwives.

In attempting to define the role of the midwife in relation to disadvantaged clients, there are some very real tensions. Providing blueprints for how care to specific clients might be targeted seems to contradict the practice of exercising 'professional' judgement and working as an autonomous practitioner. Whilst targeting may give midwives and their managers objectives to aim for, the way in which such targets are achieved needs to remain flexible so that care can be delivered that is appropriate and sensitive to individuals.

Personal prejudice and discrimination on the part of healthcare professionals may be a significant barrier to providing appropriate care to clients targeted as disadvantaged. Further, there is evidence that the needs of affluent, articulate clients with high expectations of involvement from midwives are often prioritized over less 'demanding' clients. This is clearly a very contentious issue, and is part of a wider debate around inequalities in health care provision, which has its origins in Julian Tudor-Hart's 'inverse care law' which proposes that those people most in need of health care are the least likely to receive it (Tudor-Hart 1971).

Whilst recent policies point towards the midwife taking on a broader health promotion role, this merits further consideration. The somewhat idealized notion that midwives are presented with a 'window of opportunity' to undertake this role due to their close relationship with clients needs further attention.

We have suggested that for policy visions to be implemented at practice level, commitment from managers should be matched by clarity of purpose in the documentation and provision of specific targets for practitioners. *Making a Difference* and *Supporting Families* lacked direction and, most importantly, did not contain targets. Towards the end of our research *The NHS Plan* was launched. This demonstrates a more targeted and specific vision for improving health and reducing inequalities. However, only time will tell whether its laudable visions will become practice realities.

### Acknowledgements

We thank Dr Valerie Hall, Dr Flis Henwood and Ms Francesca Pankhurst for their useful comments on a draft of this paper. We are also grateful to the English National Board for Nursing, Midwifery and Health Visiting for funding the research on which the ideas in this paper are based.

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