

## HOME BIRTH, MIDWIVES, AND THE STATE: A LIBERTARIAN LOOK

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DESPITE THE GROWING scholarly study of libertarianism over the last half-century, the application of libertarianism to homebirth has been absent. Libertarian principles and analysis offer insight into how homebirth, as an American tradition, transformed from a private matter, involving personal choices, to a matter of public policy, controlled by the state. Typically, social scientists study women and birth freedom from a feminist perspective,<sup>1</sup> but the standard feminist analysis is unpersuasive as it accepts the existing authority structure that led to regulatory capture of the birth experience by vested interests. Homebirths, attended by direct-entry midwives, offer parents a model of care that differs from the typical medical model in quality, cost, and outcome. Although nominally concerning homebirth, this paper may interest those concerned about the larger issue of state coercion, or its opposite, voluntarism.

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CITATION INFORMATION FOR THIS ARTICLE:

Kimberly A. Johnson. 2016. "Homebirth, Midwives, and the State: A Libertarian Look." *Libertarian Papers*. 8 (2): 256-275. ONLINE AT: [libertarianpapers.org](http://libertarianpapers.org). THIS ARTICLE IS subject to a Creative Commons Attribution 3.0 License ([creativecommons.org/licenses](http://creativecommons.org/licenses)).

<sup>1</sup> See Margaret Barnes's (1999) *Research in Midwifery—The Relevance of a Feminist Theoretical Framework*; Katherine Beckett's (2005) *Choosing Cesarean: Feminism and the Politics of Childbirth in the United States*; and Bortin, et al. (1994) *A Feminist Perspective on the Study of Home Birth: Application of a Midwifery Care Framework*, for a more complete discussion. For a discussion of feminism and the state, see Franzway, Court, and Connell's *Staking a Claim* (1989).

## Libertarian Scope and Principles

Homebirth is an issue worth examining from a libertarian perspective. Although some libertarians use utilitarian arguments, most thinkers agree that individuals have a fundamental right to be free from coercive restriction by others, and therefore should be allowed to exercise sovereignty and consumer choice in the marketplace. By way of examples of libertarian philosophies of peace and voluntarism, I present Murray Rothbard's exposition of the nonaggression principle, Ayn Rand on the noninitiation of physical force, and Milton and Rose Friedman's utilitarian analysis of economic choice in the free society.

Rothbard defines the nonaggression principle in *For a New Liberty: The Libertarian Manifesto*:

The libertarian creed rests upon one central axiom: that no man or group of men may aggress against the person or property of anyone else. This may be called the "nonaggression axiom." "Aggression" is defined as the initiation of the use or threat of physical violence against the person or property of anyone else. Aggression is therefore synonymous with invasion. ([1973] 1978: 23)

As a natural-rights libertarian, Rothbard argues for the right to private property and self-ownership. Based upon the nonaggression axiom, and "making no special exceptions," Rothbard sees the state as the biggest habitual aggressor. He points out that just as monarchies in the past ruled under the pretense of divine right, similarly in modern times, many view the state's extraordinary powers as special and accept its authority to override the rights of the individual ([1973] 1978).

Ayn Rand reaches a similar conclusion about how human beings may relate to one another, but for apparently different reasons. From her point of view, ethics based on "value," life, and the rational nature of human beings is paramount. Rand explains in *The Virtue of Selfishness*: "To violate a man's rights means to compel him to act against his own judgment, or to expropriate his values. Basically, there is only one way to do it: by use of physical force" (1964: 90).

In *Free to Choose: A Personal Statement*, Milton and Rose Friedman build on the commonly accepted ideas of Adam Smith that peaceable pursuit of self-interest furthers the interest of all in the society and of John Stuart Mill that the only legitimate use of force against one's neighbors is for self-protection (1980:xv-xvi). In the Friedmans' analysis, people's ability to maximize their well-being depends on their ability to exert their will in a market that delivers what consumers demand, rather than a market where supply is restricted by the state; and a market where resources are directed,

not by consumers, but by third-party payers, including the state. Specifically, the Friedmans,<sup>2</sup> in their 1962 treatment of medical licensure in chapter 9 of *Capitalism and Freedom*, make a clear case for how voluntarism is prevented in the market for healthcare. They explain how licensure affects medical services in undesirable ways and argue it is difficult to justify because it interferes with patients' right to "enter into voluntary contracts" ([1962] 1982: 122–123).

The Friedmans and Rand see a place for a small state that protects the rights of individuals to direct their own lives, while Rothbard rejects the state entirely. Rothbard and Rand build ethical systems with stark divisions between right and wrong from global systems of logical consistency, while the Friedmans weigh the costs of losing individual freedom against occasional possible utility gains. However, the Friedmans find the loss of freedom so costly that the few exceptions they find plausible prove the rule that coercion is rarely justified. Friedman and Rothbard come to their conclusions from arguments about costs and benefits and the consequences of economic law, respectively, while Rand derives her economic analysis from her ethics. These thinkers may vary in the sources of their logic—principle or consequences—yet they all arrive at the same conclusions: interested parties err in applying force to prevent individuals from voluntarily providing and purchasing services in the market for healthcare.

### **Protecting the Public: Government Growth, Pretext, and Group Benefits**

Throughout the last century, oversight of childbirth by state governments increased significantly (Stover 2011). Typically, the populace seems to accept initial government intervention and bureaucratic enforcement because the state claims it is acting on behalf of the public; however, limits on an initial intervention are short lived as government's reach continues to grow over time, rarely declining in scope or strength (Weber [1922] 1978). John Hospers (1971, 459) argues government power continues to expand as the government uses its monopoly on force, which has significant consequences for individuals: "once a monopoly of physical force exists, the powers become wider and wider, until, like the government of the United States, which was comparatively limited at its beginning... ends up interfering in every aspect of the citizen's life."

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<sup>2</sup> *Capitalism and Freedom* is officially authored by Milton Friedman alone. However, his comments in the next-to-last paragraph of the preface give convincing evidence of "authorship" to Rose Friedman and recognized her coauthorship of the previously cited 1980 book, *Free to Choose*.

Hospers's argument that government interferes with "every aspect" of its citizens' lives is evidenced in the case of childbirth. The homebirth option for mothers has waned and midwifery has declined as a normal and widely accessible profession. A century ago, women birthed in their homes with the aid of proficient midwives (Loudon 1997); today, women in many states are prohibited from making their own decisions about this private matter. Rather, licensing requirements force women to deliver their babies in hospitals with professionals whose services they do not necessarily want. This institutionalized coercion is supported by the full weight of the state (Gifford 1995). But note, from a libertarian perspective, "the government," as the term is commonly used, is not a legitimate proxy for the people; it is simply a group of individuals acting on their own behalf (Rothbard [1962] 1970). In the case of homebirth, the American Medical Association (AMA) is the group of individuals that provided, and still provides, the impetus for government action<sup>3</sup> (such as limitations on nonphysician practitioners) for its own advantage. As Rothbard ([1973] 1978) explains, government coerces for the benefit of privileged individuals under the pretense that it always knows best. Physicians, and the legislators who support them, design and approve legislation that restricts or makes illegal the use of midwives for homebirth, arguing that the end result justifies the legislation. However, the important issue to examine is how the state gains the capability to impose its authority and power on the populace. In *Our Enemy, the State*, Albert J. Nock argues it is society that furnishes the state its power since the state "has no power of its own. All the power it has is what society gives it, plus what it confiscates from time to time *on one pretext or another*" ([1935] 1972: 3–4; emphasis added). The pretext for suppressing midwifery and homebirth is that the state cares about women and, consequently, enforces laws that protect the well-being of both mothers and their babies. I will challenge that claim in later sections.

Here, we can see how Nock's argument about pretext aligns with Rothbard's analysis regarding how the government operates for the direct benefit of other individuals or groups. The AMA, a professional interest group, lobbies and writes laws specifically to advance its own political power and to protect its monopoly<sup>4</sup> on birthing, among other things. The state

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<sup>3</sup> Dr. Melissa Cheyney, a professor and midwife, conducted ethnographical research (2011) centering on how the AMA is often hostile and works to expand its power through the legislative process, resulting in restrictive laws for midwives.

<sup>4</sup> See Sue A. Blevins's (1995) work "The Medical Monopoly: Protecting Consumers or Limiting Competition?" for a detailed explanation in which she argues the AMA promotes and sustains its monopoly; included is a thorough discussion on how the AMA

justifies its use of force under the pretext that it safeguards ordinary people, but what forms is a symbiotic relationship in the medical profession where both the state and physicians benefit from restricting the choices of patients.

### **Direct-Entry Midwives and the Medical Establishment: Consequences of an Interventionist Market**

There are two main categories<sup>5</sup> of midwives in the United States: (1) certified nurse midwives (CNMs), who attended nursing school and passed the state exam (and are licensed in all fifty states), and (2) direct-entry midwives (DEMs), also known as lay midwives, which include certified professional midwives (CPMs). DEMs can be trained by formally accredited midwifery schools, apprenticeships with senior midwives, formal classes, and internships; and they may have a college degree (Cheyney 2008). Certified professional midwives receive certification from professional boards, while direct-entry midwives may not. In the United States, most homebirths with a midwife present are attended by DEMs. Because of restrictions placed on CNMs by their employers, CNMs usually practice midwifery as part of in-hospital midwife programs in a form that differs little from standard medicalized birthing.

As the American College of Obstetricians and Gynecologists (ACOG) and the AMA (2010) view it, mothers take unnecessary risks by giving birth at home. However, research demonstrates that, usually, a homebirth is just as safe for women as a hospital birth (Cohain 2010; Durand 1992; Grant 2012; Sutcliffe 2012), although some studies argue it is not always safer for the child (Snowden et al. 2015; Wax et al. 2010). Wax et al. (2010) find that infant mortality for planned homebirths was 0.20 percent (32/16,500), compared to 0.09 percent (32/33,302) for a planned hospital birth. Janssen et al. (2009) show perinatal mortality per thousand births was 0.35 among the planned homebirths and 0.64 for hospital births planned and attended by a physician. Despite the results, both ACOG and the AMA argue that if something goes awry during the birth, the best possible outcome is available through the hospital.

A body of literature shows that for nearly every measure observed, women experience more medical intervention when they choose a hospital

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became the primary source to assist with childbirth and how it limited consumer options in the market for midwifery.

<sup>5</sup> Categories for midwives vary by credentials and state; see the Midwives Alliance of North America's website ([www.MANA.org](http://www.MANA.org)) for a detailed, state-by-state analysis.

birth (Janssen et al. 2009; Johnson and Daviss 2005; Van der Kooy 2011; Wax et al. 2010). Many hospitals encourage C-sections, do not permit VBACS (vaginal births after C-section), and pressure women to give birth in ways physicians and hospitals consider more efficient (Yoshiko 2011), including the common use of medications to speed along the birthing.

Ina Gaskin (2011) asserts that much of the information given to women concerning C-sections is “incomplete or distorted” and not necessarily in the best interest of mothers. Women who homebirth are much less likely, by a wide margin, to undergo surgery. Nationally, the C-section average stands at over 30 percent (Martin et al. 2015: 2), which is up 600 percent since the 1970s, when the C-section rate was at 5.5 percent (Department of Health and Human Services 1995). The C-section rate increased from 21 percent to 32 percent, a jump of 53 percent, between 1996 and 2007 (Menacker and Hamilton 2010: 1). Cohain reports that “the increase in maternal deaths is a direct result of the overuse of cesarean surgery” (2010: 30). C-sections are much more expensive than natural births (Graff 2009) and consequently, bring additional profits to hospitals. Obstetricians have much higher rates of C-sections and also aggressively use other invasive birthing procedures, such as forceps, vacuum extraction, and episiotomies. Dr. A. Mark Durand’s study of 1,707 homebirth patients found that lay-midwife-attended homebirths have a “safety comparable to that of conventional births” (1992: 451) and require much less intervention. He reports assisted deliveries (use of Cesarean section, forceps, or vacuum extractor) for homebirths were 2.11 percent while hospital births were 26.60 percent and “that elective interventions, which are used more frequently in-hospital, may increase the risk of various adverse outcomes in low-risk women” (1992: 452).

Since it is illegal to hire a direct-entry midwife in many states, women are denied the opportunity to give birth under conditions of their own choosing, which has significant consequences for the mother. According to a hospital’s regulations in Michigan, for example, regardless of health, no women are permitted VBACs (vaginal birth after a Cesarean). Rather than allowing women to choose a VBAC, hospital policy determines the course of birth (Mekela 2011). VBACs declined from 28 percent in 1996 to only 8 percent in 2005 (Yoshiko 2011). Since many hospitals do not permit VBACs,<sup>6</sup> hospital policies often force major surgery, even if it is against the

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<sup>6</sup>According to the International Cesarean Awareness Network, 28 percent of hospitals do not currently allow VBACs, compared to 10 percent in 2004; an additional 21 percent of doctors will not allow them, even if they are not against hospital policy.

mother's wishes. If the hospital does not permit VBACs and another OB/GYN is hours away, women are left without a choice. One midwife writes about her hospital's policy and how it creates a monopoly that leads effectively to compulsory medical procedures:

It [the hospital] also benefits from those who, under law enforcement, are forced into medicalized care, often against their better judgment, because freedom of choice has been legislatively denied them. Our northeastern Michigan hospital that has been "heralded for excellence" has a "no compromise" 100% C-section policy for all women desiring to have a VBAC (vaginal birth after cesarean), no exceptions, and there are no medical alternatives otherwise available within a four-to-six hour drive. It is a medical monopoly at its finest, on just my local level alone. (Mekela 2011: 201)

If many states did not ban direct-entry midwifery, creating a medical monopoly would be difficult for physicians.

In a free market, women would choose the birthing option that they felt was safest for themselves and their babies. For example, although now rarely occurring in hospitals, VBACs are common for homebirths and have proven to be successful. The Cheyney et al. (2014) study, which included 16,924 homebirth participants, had a VBAC success rate of 87 percent, with 94 percent (n=915) of the VBACs completed at home. The American College of Obstetricians and Gynecologists' official position is that they do not support VBAC homebirth and that VBACs are hazardous and potentially unsafe.<sup>7</sup> In an issue of their journal *Committee Opinion* published in 2011, they stated a position that they also reaffirmed in 2015: "The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice considers a prior cesarean delivery to be an absolute contraindication to planned home birth" (American College of Obstetricians and Gynecologists 2011: 2).

### **Organizational Structure, Lobbying, and the State**

Through organizational efforts and state enforcement, physicians who believe they protect women from the bad consequences of their birthing decisions also benefit from laws passed by politicians restricting homebirth. This sort of thing is not new in the medical profession. Ronald Hamowy, in *The Early Development of Medical Licensing Laws in the United States, 1875–1900*, argues that from the beginning, the AMA organized itself and used the

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<sup>7</sup> For a thorough summary and other answers to medical objections concerning homebirth, see Archie Brodsky's "Home Delivery."

political system to impede competition. Hamowy writes, for instance, about how the AMA could access state legislatures to increase its power: “The success of their campaigns in the state legislatures to stiffen requirements for medical practice encouraged them to view government as an ally who could potentially place vast powers in their hands” (1979: 91).

Hamowy also details how early on doctors may have believed in the benefits to public health of their reforms, but simultaneously operated in their own self-interest. The AMA formed the Committee on Medical Legislation

in 1901 as part of its drive to increase the political effectiveness of the profession both at the national and state levels. Its primary purposes were to bring about the reforms sought by the medical fraternity and to give direction to the widely disparate lobbying efforts of state societies. (1979: 93)

The AMA also created the Bureau of Medical Legislation to collect and house “information on the state of draft bills, laws, and court decisions relating to health matters, with particular concentration on the issue of medical practice” (1979: 93). Today, it continues to promote these ends through organizational structure and lobbying efforts, enabling the medical establishment to use the state to legally take control of homebirth. By sitting on state licensing boards, physicians gain entrée into and influence in the legislative process. As Sarah Anne Stover explains: “Physicians and legislatures using state powers to protect birth as a physician enterprise are further aided by the legal structure of state licensing procedures” (2011: 338). Essentially, this structure produces government-enforced monopolies; because of state coercion, those who violate midwifery laws are often arrested, prosecuted, and jailed, and parents-to-be are sometimes threatened with accusations of child abuse if something goes awry during the delivery. Consequently, by practicing midwifery, some midwives take the risk and defy the law, thus jeopardizing their livelihoods, and possibly personal freedom, to help women give birth under circumstances they believe are best for themselves and their babies (Brock 2004).

Through lobbying efforts, legislators at both the state and federal level are influenced by medical organizations that spend large sums of money to represent physicians’ demands. In 2010, the AMA spent nearly twenty-three million dollars to lobby Congress, and in 2015, the AMA’s spending reached over twenty million dollars in the first six months of the year (Rodriguez 2015). In their role as representatives of the state, politicians are influenced by this lobbying, and they pass laws under the pretext of protecting public health. Yet, legislators do not comprehensively understand the implications

of many of the laws they support and pass in the name of public safety. Stover addresses this point:

Ultimately, health outcome data indicates that by prohibiting direct-entry midwives from practicing, legislatures are jeopardizing the health and well-being of women and infants. Legislatures are not accomplishing the goals of 'promoting public health' and 'protecting mother and fetus from incompetent providers' through overly restrictive statutory midwifery prohibitions. (2011: 334)

Compared to the AMA, which has persuaded the state to impose legal penalties for homebirth, midwives do not have the same access to legislators or the same lobbying resources. Historically, midwives functioned independently and, therefore, were not formally organized as a group; as a result, they could not defend their positions against laws specifically passed against them. Due to midwives lacking formal organization, Mekeda Kamara (2011) contends, the state opportunistically gained control of the birthing profession; this enabled the medical establishment to marginalize the midwifery profession. Kamara (2011: 158) writes: "The 'powers that be' wrested control and definition of the movement because of our lack of collective unity as midwives, our inability to build grassroots citizen support, and lack of autonomy in our profession."

In the past, since most Americans were unaware of the conflicts over policy issues between the medical establishment and midwives, the profession gained little support from the general public. This lack of attention resulted in increased government regulations and even caused many direct-entry midwives to stop practicing. With fewer women entering the profession, it became more difficult to find a midwife in many states, leaving women with fewer options (Runes 2004).

### **Medical Licensing, Government Programs, and the Free Market**

The AMA mandates all physicians must attain a state medical license to legally practice medicine. Based upon principles of nonaggression and the free market, libertarians consider licensing by the state as undermining personal freedom and impeding economic activity. Medical licensing administered through the state apparatus gives wide-ranging privileges to those belonging to the AMA and ACOG, while restraining other medical practitioners. Highly competent professionals, such as midwives and physicians' assistants, are excluded from the market due to medical licensing, which is often arbitrarily enforced (Huebert 2010). Due to medical licensure, the number of physicians in the market is reduced. This artificially raises prices for patients, lowers quality over time, and limits consumer choices

(Ruwart 2003). Licensing offers advantages for doctors and creates problems for not only midwives, but parents-to-be who seek an alternative to a hospital birth.

Ending medical licensure would not only increase patient choices but improve products and decrease healthcare costs (Huebert 2010). George Reisman ([1994] 2009) argues that the free market, unhampered by licensing legislation, gives consumers a better product at lower prices through the profit motive and competition, which are essential to a free market. Other libertarian scholars similarly have written about the ramifications of medical licensing in the United States. Hans Hoppe (2009) asserts the current US medical system is inefficient and points out that this is not due to free-market complications but government intervention. To fix the problem, he submits, there is a need to eradicate licensing and to decentralize, as well as make other important changes. Decentralized, unlicensed provision that can meet diverse demands for services already exists in many areas of economic life, plainly illustrated by, for example, the range of consumer choice in haircuts, from Supercuts to a swanky, upscale salon. Reisman explains the process by which quality will improve, with the added benefit of better meeting the medical needs of people with fewer resources:

In addition, in a fully free market—that is, one without licensing legislation—medical care would almost certainly be offered by a broad range of providers catering to different needs of the market, just as today restaurants and clothing retailers range from McDonalds and Walmart at one end to Michelin star-rated type restaurants and the fanciest Fifth Avenue and Rodeo Drive boutiques at the other. To a great extent, the medical needs of poorer people could be adequately served by men and women who presently must practice merely as nurses, pharmacists, or paramedics. Today, the only source of medical care for such people is licensed physicians. The situation is analogous to requiring that a poor person who would be happy to buy a hamburger at McDonalds and can afford to do so, buy his hamburger at a much more expensive restaurant, that he cannot afford. ([1994] 2009)

E. Richard Brown (1979) asserts that government programs and participation in medical licensing provide markedly worse care for the middle class and the poor. This encompasses a gross shortage of doctors and long wait times for those in need of medical attention. Brown explains the serious consequences of government intervention in medicine: “Instead of creating a humane and accessible medical care system, Medicare and Medicaid have helped fuel inflation in medical costs by dumping new funds into a privately controlled system ready to absorb every penny into expansion, technology, high salaries, and profits” (1979: 2). Ultimately, eliminating all government

interference in medicine that supports a collectivist system, including Medicare and Medicaid, would better serve the populace (Brown 1979).

### **Justified State Coercion with Unintended Consequences**

Some researchers argue that state coercion within the birthing sector is justified to protect the public; for example, such views are expressed by Ivy Lynn Bourgeault (2006) and Sarah Anne Stover (2011). Bourgeault's research argues for the importance of the state maintaining its legitimacy and power, while demonstrating that it cares about its citizens. Bourgeault further contends that state intervention is a significant tool to empower women, who have been oppressed by society. Likewise, although Stover supports legalization of direct-entry midwifery in all fifty states, she explicitly argues that state supervision and coercion through licensing midwives is both desirable and justified to protect the public. Specifically, she writes: "A prohibition on direct-entry midwifery is a legitimate function of a state's power to license and regulate health professionals" (Stover 2011: 311). She supports as valid the state's ability to use its power against noncompliance, and claims, "It is recognized that states are *legitimately exercising their police power* to protect the public's health and safety when they regulate or license direct-entry midwives" (2011: 324; emphasis added). Stover suggests allowing direct-entry midwives to practice, but only under the condition they apply for and receive the required licensure approved by the state. What these writers miss is the role state power plays in creating a system likely to be coopted by special interests that benefit from restricting the services allowed under that system. Libertarians, in contrast, recommend removing the power of the state to interfere in personal decisions and restrict the market. Legitimizing midwives by licensing them, as physicians and nurses are licensed, leaves the problematic power structure in place. It leaves the public vulnerable to midwife-friendly laws being coopted by special interests—just as we see with existing physician-friendly laws.

Often, when passing legislation, political leaders do not think about the long-term, unintended consequences (Hazlitt 1946), particularly when it comes to understanding the implications of their decisions for a free-market system. In the field of homebirth, authorities working with state governments may not realize that, to the average family, the voluntary exchange of goods and the freedom to choose medical providers are critically important. Witness those who seek the assistance of direct-entry midwives for homebirth. In many states, medical access is limited because families live in rural areas where the closest obstetrician can be an hour or two away. In Alabama, for example, thirty-six counties (out of sixty-seven) do not have obstetricians or hospitals with an obstetric division (Kazek 2012). A trip to the obstetrician

involves time missed from work (often without pay), expensive and difficult transportation, and childcare arrangements; the doctor's visit becomes a tremendous burden, particularly during critical weekly visits toward the end of pregnancy. Some states, by preventing direct-entry midwives to legally practice, are not only preventing a voluntary exchange between two people, but forcing severe hardship upon families.

Legalizing direct-entry midwifery in these areas may not only reduce mortality, but ease families' emotional and economic hardship. The profits of physicians and hospitals would be reduced if outside competition from DEMs were not deliberately eliminated by the state. Melissa Denmark underscores this point, stressing that, "The medical opposition remains alert to opportunities to rid the playing field of its competitors" (2006: 257). Despite the needs and wishes of the citizenry, by thwarting consumer preferences, the state shelters doctors from free-market competition. As previously discussed, doctors have a distinct financial incentive to gain full control of birthing and do so using the state to gain privileges. Doctors and hospital administrators want women under their care not only for the profits to be gained from the actual birth, but also because profits are drastically increased when women are subjected to additional procedures, such as the C-section—"the most common operating room procedure in the country" (Yoshiko 2011: 2).

### **Safety in the Market through Voluntarism**

Without the state's medical-licensure mandate, the question arises as to how consumers will choose a qualified doctor. The answer from a libertarian perspective can be found in the principle of voluntarism, which centers on free association. Although the medical establishment argues against this, claiming that patients need protection, it is the free market that can provide both safety and consumer satisfaction. If healthcare providers were allowed to operate entirely through voluntary means, such as competing voluntary accreditation agencies, this would provide both safety and consumer satisfaction. Voluntarism would aid the consumer in making choices for medical care, while highlighting the reputations of the providers (Hoppe 1993). Friedman also suggests that patients could be satisfied and made safer through the simple solution of "certification alone," as opposed to full-blown licensure ([1962]1982: 149).

Therefore, in allowing providers to seek certification or accreditation from agencies voluntarily, the decision would be in the hands of the patient, and criteria for accreditation would address concerns expressed by consumers in the market. Free operation of honest accreditation agencies would allow

patients to evaluate the claims of competing accrediting authorities. Further, patient reviews would be an important source of patient decisions, as with reviews of products on Amazon or ratings on eBay. The reviews of healthcare providers and competition among agencies would offer patients the best information about the qualifications and experience of specific providers. This would grow the market and provide more services and choices for consumers, further extending the bounds of voluntarism.

In addition, if the state permitted voluntarism to operate and midwives and physicians to compete through the free market, quality most likely would increase and costs would decrease for the consumer, while the expressed preferences of consumers would be better fulfilled. Marsden Wagner (2006), a consultant for the World Health Organization (WHO), found that if midwifery care were permitted to expand, and if birth were demedicalized, it would save the United States twelve to twenty billion dollars a year. Simply bringing the Cesarean rate under the WHO standard of 10 percent would save the United States about \$1.5 billion per year. Therefore, an increase in direct-entry midwifery would not only provide freedom of choice for consumers, but would also result in a decreased healthcare costs.

### **Homebirth and Libertarians**

When laws prohibit choosing a midwife, the feminist response has been to remold state regulation. Rather than ask about which state regulation should be imposed, a better question for feminists to address is whether interference by the state is helpful to women, specifically because the state apparatus is used to restrict their choices, despite its allegedly benevolent justification. Since more women, forced by law to go to the hospital, are having more C-sections and suffering higher mortality rates, they would benefit from additional options. As with most cases of state collusion with interest groups, someone profits; in this case, it is the hospitals and physicians rather than patients. Protecting physicians from the competition of midwives is only possible because the state colludes to limit the market. This results in a transfer of wealth from expectant couples, insurance-plan participants, and taxpayers to physicians, insurance companies, and regulators.

The homebirth debate is fertile ground for libertarian discussion because homebirths are another example of how the best options from the consumer's perspective are systematically suppressed by the state. Yet, despite the state's control over this private matter, this issue has received little analysis from libertarians. One reason could be that 67 percent of libertarians are men (Pew Research 2011). However, given how family dynamics have changed over the last half-century or so, the experience surrounding birth has

also changed significantly since the 1950s. Men are no longer exiled to the waiting room, but are part of the life-changing event. Experts agree that fathers-to-be are integral to the birthing experience; they are even indispensable partners for the mother and are fundamental to the success of their spouses in the birth process. Ina May Gaskin, an authority on midwifery, writes that the birthing process changes men as well as women: “Laboring women aren’t the only ones going through a deep transformation when a baby is born. Babies’ fathers also go through powerful inner changes as well—especially when they are ready to be as close to their partners as possible during the process” (2011: 167).<sup>8</sup>

Since the essence of libertarianism is the nonaggression principle and promoting a society based on a principle of voluntarism, libertarian social theory is an excellent source to explain how the homebirth option would benefit society. Many midwives live a libertarian philosophy, but are unaware of how their decisions to help parents make their own choices regarding birth are deeply entrenched in the principles of nonaggression and voluntarism.

We can reasonably speculate how birth would change without state interference and coercion. If the use of force by the state was eliminated and families could choose their expert medical advisors and choose homebirth voluntarily, the benefits would be immediate. Without state intervention, future mothers would have a choice of who should help with the birth, and direct-entry midwives could fill the gap, which would increase free-market options. If the market could operate without interference by the state, it is likely that midwifery would grow, and more women would find homebirth a good alternative (Runes 2004). It is plausible that many more women would employ a midwife, for personal preference, cost, convenience, or other reasons, if the state reversed course and allowed it. Simply loosening licensing laws would increase competition and improve products and services while lowering costs. A comprehensive solution, based upon libertarian social theory and economics, would include eliminating paternalistic mandates by the state that restrict the choices of where, and with whom, women may give birth.

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<sup>8</sup> Gaskin, the most well-known direct-entry midwife in the United States, is a critic of the maternity-care system. She practices without a medical license, was awarded an honorary doctorate, and has an obstetric procedure named after her: the Gaskin maneuver, which is taught in medical schools. For more on Gaskin, see the article by Samantha M. Shapiro (2012).

## Conclusion

This paper describes the important connection between homebirth and libertarian principles of nonaggression and consumer choice in a free market. In the past, when intellectuals argued for homebirth, they contended that women were exploited by the medical system, and sought to use the state as the mechanism to make birthing options better for women. Libertarians view this argument as unacceptable, given that state actions violate principles of nonaggression and voluntarism. Libertarian thinkers Rothbard, Hospers, Rand, and the Friedmans have provided a framework for analyzing the actions of the state and its vested interests in defeating voluntarism and restricting what preferences people can express in the market. Since libertarians seek a free society in all areas of life, birth choice ought to be included in the discussion.

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