

A Survey of Childbearing in Britain

A preliminary report issued by a Joint Committee of the Royal College of Obstetricians and Gynaecologists and the Population Investigation Committee¹

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1. *Summary and conclusions*

A questionnaire inquiry into the social and economic aspects of childbearing has been carried out by the Health Visitors of 424 Maternity and Child Welfare Authorities (92% of all such authorities in England, Wales and Scotland). The mothers of all babies born during a single week were visited, and interviews were successfully completed with more than 90% of them. A total of 13,687 mothers co-operated, of whom 7287 answered a questionnaire dealing mainly with the availability of the maternity services and the use made of them, and 6400 a questionnaire on expenditure on medical and other costs associated with the birth of the baby.

In the spring of 1946, when this inquiry was undertaken, the conditions of childbearing were still affected by wartime measures such as schemes for evacuating expectant mothers, the direction of labour, etc., and by acute deficiencies in housing, maternity beds and medical personnel, which were also attributable to the war. These latter deficiencies existed, to some extent, in many areas before the war and are unlikely to be made good for many years. It is felt, therefore, that although this study has been undertaken in an 'abnormal' period, it will yet give a substantially accurate picture of the problems of childbearing both to-day and for some time to come.

This paper gives an analysis of preliminary tabulations of the care received, and expenditure incurred, by mothers of six different occupational groups. No attempt

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has been made to analyse all the tabulations that will become available, or to refer in detail to previous studies, as this will be done in later publications.

Antenatal supervision is started relatively early in pregnancy by the majority of all married mothers. However, differences are found between the occupational groups which suggest that there is still both a need to educate working-class women in the importance of seeking medical advice as soon as they know that they are pregnant, and, also, particularly in rural areas, to provide more accessible facilities for antenatal care.

Institutional confinements are most frequent (77%) among wives of professional and salaried workers and least frequent (43%) among wives of agricultural workers. In each occupational group more first than subsequent births take place in institutions.

The better-off mothers are more often delivered by obstetric specialists and doctors than the poorer, and also more frequently receive analgesia. The difference between the groups is most marked for domiciliary confinements, but is found, also, for confinements in each type of institution.

Comparatively few mothers (13% of all confined at home) said that they had been unable to book a bed in hospital. Some indication of the shortage of hospital beds is, however, shown by the fact that many mothers in each occupational group are discharged from hospital before the fourteenth day after delivery. In contrast to hospital confinements, very few mothers are discharged from nursing homes before the fourteenth day.

Postnatal examinations by doctors or specialists have been given to less than a third of the mothers. Such examinations are most frequently made after hospital confinements and after first births. But even in the most favourable cases (first births in hospitals) only 48% are given a postnatal examination.

The costs of childbearing are high. For legitimate first births they average £40, and for legitimate subsequent births, £27. Working-class mothers spend considerably less than the better-off, but, in spite of this, it is likely that, when expressed as a proportion of the family income, the heavier burden of expenditure is borne by the poorer mothers.

In all occupational groups considerably more is spent on baby clothes and equipment than on medical and institutional fees, and it is clear that provision of free medical care will not greatly relieve the cost of childbearing.

The general conclusions are that, in spite of the great improvements in the maternity services that have taken place since the 1918 Maternity and Child Welfare Act, there is still great inequality in the care received by different social groups. In certain aspects, particularly postnatal care of the mother and the provision of analgesia, there is room for considerable improvements for all classes. The costs of childbearing are so high that they are likely to deter many mothers, of all classes, from having children. It is not unlikely that, in many working-class families, this expenditure has to be met by borrowing or drawing upon savings. A substantial reduction in the costs of having a child is only likely to be achieved by lowering the price of baby clothes and equipment.

This inquiry, which was supported by a grant from the Nuffield Foundation and a donation from the National Birthday Trust Fund, has been made possible by the co-operation of the Medical Officers of Health and Health Visitors of the 424 Maternity and Child Welfare Authorities in which the survey was carried out. The Joint Committee would like to take this opportunity of thanking them for the invaluable help they have given.

2. *Aims and methods*

(a) *Nature of the survey*

This article is a preliminary report of a questionnaire inquiry into the social and economic factors associated, in Great Britain, with pregnancy and childbearing. The study was planned by a Joint Committee of the Population Investigation Committee and of the Royal College of Obstetricians and Gynaecologists, under the chairmanship of Professor James Young. The Royal Commission on Population gave their support to the inquiry, and the Society of Medical Officers of Health and the Association of County Medical Officers commended it to their members. The support of these bodies has been a critical contribution to the success of the inquiry.

The members of the Joint Committee felt that effective policies for removing the deterrents to parenthood and increasing the availability of the maternity services could be framed only on the basis of a study of the problems actually encountered by mothers at the present day. This inquiry was planned, therefore, to obtain information, not available from other sources, about expenditure during and after pregnancy, the availability of the maternity services to different social classes and in different parts of the country, the use made of them, the need for extra domestic help for expectant and nursing mothers, and other similar questions.

(b) *Choosing the samples*

It was felt that to obtain this information would necessarily involve personal interviews with a sample of mothers, whose experience could be regarded as typical of that of the whole population of women now bearing children. Thus the inquiry should represent all types of administrative authorities, all geographical regions, and mothers of all social groups.

The value of such interviews would be greatly increased if they were carried out by people who had an intimate knowledge of the mothers' problems, and who had access both to the mothers and to the records of midwives and Local Authorities. Such a group of people were Health Visitors. In England and Wales they normally visit the mothers of about 96%¹ of the children born, and the greater number of interviews could thus be carried out in the normal course of their routine duties. However, the majority of Health Departments were known to be under-staffed, and the Joint Committee felt that they could neither ask for, nor would they be likely to obtain, the co-operation of Local Authorities and Health Visitors unless

¹ *Summary Report of the Ministry of Health for the year ended 31 March 1945* (Cmd. 6710), p. 21.

the demands on their time were kept to the minimum compatible with the requirements of the investigation.

At the suggestion of Dr D. V. Glass, it was decided to take, as the sample of mothers to be interviewed, all women who were delivered in England, Wales and Scotland during a single week. The advantages of taking a sample in time from all authorities, rather than a sample from the authorities themselves, were that, for a given total number of interviews, the work to be undertaken by each Health Visitor was smaller, the sample more easily checked, the field-work more rapidly completed, and the problems of administration eased.

It was decided to attempt to interview all women delivered during the week 3-9 March 1946, 8 weeks after the birth. This interval of 8 weeks was considered to be long enough for the mother to have returned home, purchased layette, pram, etc., received bills for the confinement, and made arrangements to take her baby to the Infant Welfare Centre. On the other hand, the details of her expenditure and experiences during pregnancy and the lying-in period would still be fresh in her mind.

Detailed plans of the proposed inquiry were submitted to the Councils of the Society of Medical Officers of Health and the Association of County Medical Officers. In each case, approval was given to the suggestion that the field-work should be carried out by Health Visitors, and the Councils recommended their members to take part in the inquiry.

The Medical Officers of Health and the Town Clerks of the 458 Local Authorities in England, Wales and Scotland which undertake Maternity and Child Welfare, were approached by means of a circular letter, which described the objects and methods of the inquiry, and asked them to allow their Health Visitors to undertake the interviews. 424 (92%) of these authorities promised, and have since given, their full support to the survey. This response far exceeded the most sanguine hopes of the Joint Committee.

(c) *The questionnaire*

The questionnaire used in this inquiry was evolved, in the following way, from a draft presented to the Joint Committee by Dr D. V. Glass. An exhaustive list of questions was tried out on a small sample of mothers by professional interviewers. As a result of this test, some questions were eliminated and others differently framed. The remodelled questionnaire was next tested by Health Visitors in Bristol, Inverness and Kensington. Verbatim answers were recorded, and at the end of each form the Health Visitor was asked to add her criticisms. Further modifications were made as a result of these trials, and codes were worked out for all factual questions, so that the answers could be recorded by encircling appropriate numbers at the side of each question.¹

At this stage it took nearly an hour to complete each interview, and it was therefore necessary to reduce the length of the questionnaire for the sake both of

¹ In designing the final lay-out of the questionnaires, Dr Henry Durant, Director of the British Institute of Public Opinion, gave most valuable help.

the mothers and the Health Visitors. Rather than omit further questions, the original questionnaire was divided into two separate questionnaires, *A* and *B*. Questionnaire *A* dealt mainly with the use made of the maternity services, *B* with the costs of pregnancy and confinement. Certain questions, however, were common to both. By this device the time necessary to complete each questionnaire was reduced to about 25 min.

Before distribution of these questionnaires, the 424 co-operating authorities were divided by random selection into two groups. All those in one group were sent *A* questionnaires and in the other *B* questionnaires. In no case did a single authority receive both types.

In the following summary of the information asked for on these questionnaires, (*A*) indicates that the question appeared on the Maternity Services Form and (*B*) on the Costs Form.

Status of family was given: by the occupation of husband (*A* and *B*), education of mother (*A* and *B*), and the number of occupants per living room and bedroom (*A* and *B*).

The mother was classified: by her age (*A* and *B*), date of marriage (*A*), order of birth of the child (*A* and *B*), and the interval between the present and last previous birth (*A* and *B*).

Details of antenatal supervision: when it was started (*A* and *B*), who gave it (*A* and *B*), and how often the mother was seen (*A* and *B*).

Details of the confinement: where it took place (*A* and *B*), who actually delivered the child (*A*), what analgesia (if any) was given (*A* and *B*), and the number of days the mother stayed in hospital or nursing home (*A* and *B*).

Information about the baby: birth weight (*A* and *B*), type of feeding (*A* and *B*), and survival (*A* and *B*).

Particular problems of: the working mother (*A* and *B*), and domestic help (*B*).

Comments on: the services provided (*A*), the need for Home Helps (*B*), why breast feeding was stopped (*A*), and why vitamins, orange juice, etc., were not taken up (*B*).

Expenditure on: confinement, layette, maternity garments, and equipment for the baby (*B*).

Cross-checks were arranged between the questions, so that the majority of recording errors would be readily observed.

(d) *Organization of the field-work and checking of the completed forms*

Sufficient copies of the questionnaires and of a detailed memorandum on the method of conducting the survey were sent, well in advance, to the co-operating Medical Officers of Health. They were asked to enter, on lists provided, the names and addresses of the mothers of all children whose births were notified during the week 3-9 March. If any one of these had left the area of their Authority, her new address and the name of the Local Authority area into which she had moved were to be entered on a form and sent immediately to the Joint Committee. As these forms for outward transfers were received, they were despatched to the new

Authority. Separate lists were kept of such transfers, several thousand of which were re-allocated before the week selected for making the interviews. In many cases the receipt of these forms was the first intimation received by the Medical Officer of Health of the arrival of mothers in the area of his Authority.

It was emphasized in the memorandum that mothers of all income groups should be included in the survey. When a mother refused to co-operate, or could not be interviewed for any other reason, a form was to be returned giving the reason for failure, and as many data relating to the mother as could be extracted from the records. A note of the reason for failure was also to be entered on the birth notification list.

A complete check of the sample was available in the birth notification lists, which were returned with the completed forms. From these it was possible to ensure that all mothers, who had left an Authority before being interviewed, had been traced elsewhere.

Most of the interviews were carried out in the first week of May 1946, and all the completed forms had been returned to the Joint Committee by the middle of June. Each form was carefully checked, and any omissions or discrepancies were referred (via the relevant Medical Officer of Health) to the Health Visitor who had actually carried out the interview. Some 3000 queries were made, and most of them were answered in time to be included in the survey.

After the data had been prepared for machine tabulation, a sample of one card in every fifty was checked against the original forms, to detect possible punching errors. After this, the cards were sorted so as to isolate any which might have been wrongly coded. These were corrected and repunched. The tabulations subsequently made, in every case, have been balanced against known marginal totals. There is thus every reason for confidence both in the quality of the original data and in the accuracy of the tabulations.

The tabulations have not yet been completed, and this article is limited to data on the maternity services derived from the *A* forms only, that is to say, half the material which will eventually be available. But a preliminary analysis of the costs of childbearing has also been made, and is included in this report.

3. *Adequacy of the sample*

(a) *Loss through non-co-operation and late notification*

It was hoped to interview all women in England, Wales and Scotland delivered during the week 3-9 March 1946. Two immediate sources of loss were the inability of 34 Maternity and Child Welfare Authorities to co-operate, and the exclusion from the survey of births notified later than two weeks after delivery. An estimate of the loss from these two sources has been based on birth registrations during the chosen week. The Registrar-General kindly supplied estimates derived from actual registrations during this period in the Great Towns. These include late registrations of births occurring before 3 March 1946, whereas the notifications with which they are compared are of actual births within the week considered. A comparison

between the two, therefore, will form only a rough check on the completeness of the sample. The number of registrations allotted to the non-co-operating Authorities has been based on their proportional share of all birth registrations in 1945. This was done because figures for registrations during the specific week were not available for each separate Authority.

The estimated birth registrations are compared in Table 1 with the number of notifications contained in the lists supplied by the Local Authorities.

Table 1. *Estimated registrations during the week 3-9 March 1946*

Type of authority	Estimate of birth registrations in week 3-9 March 1946	Total notifications supplied to the Joint Committee
424 co-operating	15,416	15,130
34 non-co-operating	1,279	—
All types	16,695	—

The number of notifications agrees closely (within 2%) with the estimated registrations in the co-operating Authorities, and the loss of information resulting from late notifications may, therefore, be regarded as small. It is estimated that the birth notification lists, supplied by the Local Authorities, comprise about 90% of all births in Britain (excluding Northern Ireland) during the chosen week. Approximately 8% of notifications were made in non-co-operating Authorities, and a further 2% may have been missed through late notification.

(b) *Loss through missed interviews*

Some of the mothers on the birth notification lists refused to be interviewed, or were omitted because they were ill, could not be traced, or because of the illness of Health Visitors. In every case the reason why the visit had not been completed was recorded on the list of notifications. The Health Visitors were also asked to return a form for such mothers, and enter on it any information available from records. In checking the lists and forms, great care was taken to make sure that these instructions had been followed and, if they had not, the Medical Officers of Health were asked to supply the missing data.

Table 2 gives the proportion of interviews which were completed, and the reasons why the remainder were not undertaken.

Table 2. *Proportion of successful and unsuccessful interviews*

Successful interviews (%)	Unsuccessful interviews (%)			Total (%)	Total notifications
	Mothers refused	Mothers untraced	Forms spoiled		
90.5	1.9	7.3	0.3	100.0	15,130

Less than 10% of interviews were missed and the greater part of this loss was from untraced mothers. Refusals were only encountered in 2% of all attempted interviews.

(c) The bias introduced by missed interviews

The complete sample has been so nearly covered that serious bias was only to be expected if mothers had been omitted mainly from a single group, such as 'those whose child had died', or 'those of a particular income level'. Many of the incomplete forms contain information derived from records of Local Authorities and the personal knowledge of Health Visitors. The items most frequently recorded are, whether the baby was live or stillborn, age of mother, parity of birth, and husband's occupation. On examining these forms, it appeared that a large proportion of the untraced mothers were unmarried. Often an illegitimate birth had been kept secret from parents or relatives, and the Health Visitor concerned had rightly felt unjustified in pressing for an interview.

Both traced and untraced mothers were grouped, according to the husband's occupation, by a method described in § 4. More than 99% of the traced but only 35% of the untraced were so classified. However, it is not unreasonable to assume that the 65% of untraced mothers, whose husbands' occupations were unknown, fell into each occupational group in approximately the same proportions as did the 35% already classified. This assumption has been made in calculating the percentage loss of information for each group. In any case, the total picture is scarcely affected, since the proportion of untraced mothers was itself only 7.3% of all mothers. The figures are shown in Table 3.

Table 3. *Estimated incidence of failed interviews in each occupational group*

	Wives of					All un- married mothers
	Pro- fessional and salaried workers	Black- coated wage earners	Manual workers	Agri- cultural workers	Men in other occupa- tions	
Failed interviews as a per- centage of mothers in each class	9.9	5.6	7.4	6.2	10.1	36.0
Total of traced and un- traced mothers in each class	1253	1529	9706	609	878	1078

It is estimated that about one-third of the unmarried mothers have been omitted, i.e. three to six times as large a proportion as in any of the other groups. This may be an overestimate, as the fact of illegitimacy is more likely to be known for untraced mothers, than is the husband's occupation. But, even after making full allowance for this possibility, the proportion of missed interviews is still greater for unmarried mothers than for any other of the occupational groups. With this one exception, the amount of information lost varies little between the groups.

Interviewed mothers are next compared with the uninterviewed in respect of the proportion of stillbirths. Numbers of stillbirths per 1000 total births have been calculated for the Maternity Services Survey only, and are found to be higher for the uninterviewed than for the interviewed, being respectively 74.4 (323 live and

stillbirths) and 25.5 (7347 live and stillbirths). The stillbirth rate is equally high among all groups of un-interviewed mothers. Thus, there has been a tendency for mothers of all groups to escape interview if their babies were stillborn. However, this will not be a serious cause of bias owing to the small number of stillbirths involved (24 in all).

It was noticed that a high proportion of the interviewed unmarried mothers had been delivered in institutions, and it therefore seemed possible that the majority of untraced mothers in this group had been confined at home. An examination of the available data did not confirm this possibility, 69% of the un-interviewed having been delivered in institutions, as compared with 60% of the interviewed.

It may be concluded, from the previous paragraphs, that the loss of information resulting from refusals and inability to trace mothers has introduced an appreciable bias mainly in the under-representation of unmarried mothers. However, those who have been interviewed appear to be a representative sample of unmarried mothers, and the under-enumeration will not affect comparisons between the occupational groups nor, in view of the numbers involved, will it reduce, materially, the value of conclusions drawn from the whole sample.

(d) Comparison of the loss of information in the Maternity Services Survey with that in the Costs Survey

The 15,130 mothers returned on the birth notification lists of the 424 co-operating authorities, were divided between two inquiries: the Maternity Services Survey and the Costs Survey. In each survey 212 authorities took part. A higher proportion of refusals was expected for the Costs Survey as it went into intimate details of expenditure. In Table 4, therefore, the proportion of refusals, untraced mothers and completed interviews in the two surveys is compared.

Table 4. *Maternity Services Survey and Costs Survey compared for proportion of successful and unsuccessful interviews*

Survey of	Successful interviews (%)	Unsuccessful interviews			Total percentages	Total notifications
		Mothers refused (%)	Mothers untraced (%)	Forms spoiled (%)		
Maternity Services (A)	91.5	1.4	7.0	0.1	100.0	7965
Costs (B)	89.3	2.4	7.7	0.5	99.9	7165

There is a slightly higher refusal rate in the Costs Survey, but the total loss of information is small for both. There are considerably more notifications in the Maternity Services Survey than in the Costs Survey. The reason is that in allotting authorities at random to each survey it happened that the three large towns, Birmingham, Liverpool and Glasgow, were all included in the Maternity Services inquiry. As a result, 46% of mothers in this survey were interviewed in County Boroughs as compared to 42% in the Costs Survey. When a comparison is made of the proportion of mothers in each Survey distributed in each occupational group

it is found that wives of manual workers are slightly over-represented in the Maternity Services Survey, and of agricultural workers in the Costs Survey.

Table 5 shows the estimated loss of information from each occupational group in the two surveys.

Table 5. *Estimated incidence of failed interviews in each occupational group in Maternity Service Survey (A) and Costs Survey (B)*

Survey of	Failed interviews among					
	wives of					All un-married mothers (%)
	Professional or salaried workers (%)	Black-coated wage earners (%)	Manual workers (%)	Agricultural workers (%)	Men in other occupations (%)	
Maternity Services (A)	6.4	5.9	6.5	6.1	9.7	37.1
Costs (B)	13.8	5.2	8.7	6.7	10.7	36.0

The loss of information for the professional and salaried group is twice as high in the Costs Survey as in the Maternity Services Survey. However, the total loss is so small that this difference is unlikely to introduce a serious bias. In the other occupational groups the loss of information is of similar proportions in both surveys.

It will be gathered from the preceding paragraphs that all groups of married mothers are adequately represented in each sample. Unmarried mothers have been under-enumerated to the same extent in both surveys.

4. *Occupational groups and their characteristics*¹

(a) *Social classification of mothers*

The remaining sections of this paper are mainly concerned with social class differences in the costs of pregnancy and the availability of maternity services. It was not possible to use income as the basis of a social classification, as this type of information is most untrustworthy. A useful classification, however, can be based on the occupation of the husband. Each mother was asked the peacetime occupation of her husband, in what industry he worked, and whether he was an employer, worked on his own account, received a salary or earned a wage. From her answers she was allocated to one of ten occupational groups. Unmarried mothers were separately classified. This method of occupational grouping is identical with that used in the Family Census recently undertaken by the Royal Commission on Population.

The number of mothers in each occupational group is shown in Table 6.

Some of the occupational groups which are only poorly represented have been combined as follows: wives of professional men, employers and salaried workers

¹ All statistics in §§ 4-7 have been derived from the Maternity Services Survey only.

make similar use of the maternity services, and expend about the same amounts on childbearing. They have, therefore, been combined into a 'professional and salaried' group.

Table 6. *Classification of mothers by the peacetime occupation of their husbands (Maternity Services Survey only)*

No. of mothers	Wives of										All unmarried mothers	Total of known occupational group
	Professional men	Employers	Salaried workers	Black-coated wage earners	Manual workers	Casual labourers	Men in armed forces	Agricultural workers	Farmers	Men working on own account		
In each occupational group	217	42	340	765	4515	35	318	264	159	230	364	7249
In combined groups	599			765	4868			264	389		364	7249*
% of all classified mothers	8.3			10.6	67.2			3.6	5.4		5.0	100.1

* 38 mothers could not be classified in any occupational group.

Wives of 'other ranks' who had no peacetime work before joining the armed forces, have been grouped with the wives of manual workers and casual labourers. The majority are young mothers of working-class background.

Wives of farmers cannot usefully be combined with any other group, and have therefore been included, under the title of 'other occupations', with the miscellaneous group of those working on their own account.

(b) *Characteristics of the occupational groups*

Parity. The relatively high proportion of wives of manual workers in the sample is partly due to differential birth-rates. Higher order births were more frequent in this group, as will be seen in Table 7. In determining birth order, stillbirths but not miscarriages have been included.

Excluding unmarried mothers, the highest proportion of first births is found among wives of professional and salaried workers and black-coated wage earners. Higher order births are most frequent among wives of agricultural and manual workers.

A surprisingly large proportion of unmarried mothers have completed a fourth or higher order pregnancy.

It is evident from Table 7 that comparisons between the occupational groups should be made, wherever possible, between mothers who have had the same number of previous deliveries.

Age of mothers. Table 8 shows the average age of mothers, grouped according to parity and occupational group.

There are only small differences between the average ages of mothers in each occupational group. The greatest differences are found when first births only are

considered. The wives of professional and salaried workers have their first baby on an average nearly 2 years later than the wives of black-coated wage earners, and nearly 3 years later than wives of manual workers. But it has not seemed necessary to take these comparatively small differences into account when making comparisons between the occupational groups.

Table 7. *Frequency of different orders of birth in each occupational group*

Birth order	Wives of					All un-married mothers	All occupational groups
	Professional and salaried workers	Black-coated wage earners	Manual workers	Agri-cultural workers	Men in other occupations		
First (%)	43.2	45.5	37.4	33.0	30.6	68.4	39.8
Second or third (%)	50.9	45.9	43.8	39.8	51.7	23.4	43.8
Fourth or higher (%)	5.9	8.6	18.8	27.3	17.7	8.2	16.4
Total of known birth order (%)	100.0	100.0	100.0	100.1	100.0	100.0	100.0
No.* in each occupational group	599	763	4859	264	389	364	7238

* Totals for the number of mothers in each occupational group vary slightly from table to table. These variations are a result of the refusals, or inability, of some mothers to answer specific questions.

Table 8. *Mean age of mothers at this birth according to parity and occupational group*

Order of birth	Mean age in years at this birth of						
	Wives of					All un-married mothers	All occupational groups
	Professional and salaried workers	Black-coated wage earners	Manual workers	Agri-cultural workers	Men in other occupations		
First	28.8	27.0	26.0	26.3	27.4	22.9	26.2
Second or third	31.8	31.5	29.9	29.4	32.5	27.0	30.3
Fourth or higher	34.0	35.1	34.5	33.2	35.7	31.4	34.4
All births	30.6	29.7	29.2	29.4	31.5	24.4	29.3

Overcrowding. Detailed questions on home conditions, which were included in the early drafts of the questionnaires, had to be omitted from the final draft because of lack of space. However, each mother was asked how many living rooms there were in her dwelling and how many people lived in them. A dwelling was defined as those rooms occupied by the mother, her family (including the present baby) and any relations and lodgers that might be living with them. In assessing the

number of people per room, children of all ages were treated as separate individuals. Density figures are given for each occupational group in Table 9.

Table 9. *Occupancy of bedrooms and living rooms in each occupational group*

Average no. of people in each living room or bedroom	Wives of					All unmarried mothers	All occupational groups
	Professional and salaried workers	Black-coated wage earners	Manual workers	Agricultural workers	Men in other occupations		
0-1 (%)	62.8	44.5	28.4	36.6	52.1	25.3	34.4
2 (%)	32.6	44.5	49.8	45.9	38.5	45.5	46.7
2+ (%)	4.6	11.0	21.8	17.5	8.9	23.9	18.7
Total (%)	100.0	100.0	100.0	100.0	95.5*	94.7*	99.8*
No. of known occupancies	593	758	4820	259	384	352	7166

* A number of mothers in each of these groups were living in hostels. For this reason the percentages do not add up to 100.

Even among the families of professional and salaried workers 4.6% are living more than two to each room. A similar degree of overcrowding is found in nearly five times this proportion of families of manual workers. Inter-group differences are, however, most striking when analysed according to the birth order of the present baby. In Table 10 percentages are given for families, grouped according to order of birth, and husband's occupation, who are living more than two people in each room.

Table 10. *Percentage of families living more than two to each room, analysed by order of present birth and husband's peacetime occupation*

Order of present birth	Families living more than two to each room among						
	Wives of					All unmarried mothers	All occupational groups
	Professional and salaried workers (%)	Black-coated wage earners (%)	Manual workers (%)	Agricultural workers (%)	Men in other occupations (%)		
First	6.9	8.6	15.5	4.7	7.5	18.8	13.5
Second or third	2.0	11.1	17.7	17.8	4.1	34.7	15.0
Fourth or higher	5.9	23.4	41.5	29.8	24.6	53.6	38.0

The families of professional and salaried workers are the only ones in which there is no increase in the proportion of overcrowding as the size of family increases. In all the other groups, families with fourth or higher order births are overcrowded approximately three times as frequently as families with a first birth only. It will be noticed that in every birth order the highest proportion of overcrowded homes is found in the group of unmarried.

These figures of overcrowding were obtained during the abnormal period of transition from war to peace. However, the picture they give is unlikely to be substantially altered in the immediate future.

Stillbirths and neonatal deaths. All stillbirths and the dates of all infant deaths were recorded. The stillbirth rate per thousand total births was 25.5 when only interviewed mothers were considered, and 27.1 when untraced mothers (where the result of the birth was known) were included. This latter figure agrees well with that of 28.5 per thousand total legitimate and illegitimate births during the first quarter of 1946 in England, Wales and Scotland.¹

Previous studies have shown that both stillbirth and neonatal death-rates increase with falling social class. Thus Rietz² found for legitimate births in Stockholm in 1918-22 that the stillbirth rate increased from 14.3 when the father's income was £600 or more to 48.9 when it was less than £240. The corresponding figures for neonatal death-rates were 11.4 and 24.0. A recent study, based on a special analysis, provided by the Registrar-General, of all legitimate births in England and Wales in 1939, has been made by the Biological and Medical Committee of the Royal Commission on Population.³ Stillbirth rates (standardized by mother's age and birth order) were calculated for each of the Registrar-General's five social classes. In passing from the most prosperous to the least prosperous class both stillbirth rates and neonatal death rates increased. The stillbirth rate for Class I (the most prosperous) was 24.0 and for Class V (the least prosperous) 40.3. The neonatal death rates for these two classes were respectively 18.9 and 30.1.

Owing to the comparatively small numbers available in the present inquiry (184 stillbirths and 211 neonatal births), the stillbirth and neonatal death rates for each occupational group are of low precision and therefore will not be discussed in detail. There is a significant difference (of 11.9 ± 5.2) between the stillbirth rate for manual workers (26.6) and professional and salaried workers (14.7). In general, the rates show the same picture as the studies referred to in the preceding paragraph, namely, an increase both in the stillbirth rate and the neonatal death rate with falling social group.

5. *Antenatal supervision*

In this survey only quantitative data on antenatal care have been collected. It was felt that it would not be profitable to attempt to assess the quality of antenatal supervision, as few mothers would be able to give a sufficiently detailed and accurate account of the care they had received, for a judgement to be made on the knowledge and conscientiousness of the midwife or doctor attending.

Each mother was asked to say who gave her antenatal supervision, and the date when she first received it. Some mothers had received antenatal care from more

¹ *Quarterly Returns of the Registrar-General for England and Wales* (no. 389) and of the *Registrar-General for Scotland* (no. 365).

² Rietz, E. (1930), *Acta Paediat.* 1X, Suppl. 3, Uppsala (as quoted by Titmuss (1943) in *Birth, Poverty and Wealth*, Hamish Hamilton Medical Books).

³ *Reproductive Wastage: Abortion, Still-birth and Infant Mortality*, Report by the Biological and Medical Committee of the Royal Commission on Population, R.C. 76 (unpublished).

than one source. In order to avoid enumerating them more than once, only the most important source of care has been considered. Mothers have been classified as attending a clinic, even if they also went to a municipal or private doctor or midwife. For mothers not going to a clinic, the sources of antenatal care were given the following order of priority: (1) doctor by arrangement with the Local Authority; (2) Municipal Midwife at her home or the mother's; (3) privately engaged 'specialist'; (4) private doctor; (5) private midwife. Thus a mother would have been classified as receiving care from a Municipal Midwife even if she had been attending a private doctor, but not if she had been attending a clinic or a doctor by arrangement with the Local Authority.

The proportion of mothers who were receiving different types of antenatal care is shown in Table 11.

Table 11. *Type of antenatal care received*

	Antenatal supervision received from							
	Antenatal clinic (voluntary or Municipal)	Doctor by arrangement with Local Authority	Municipal Midwife at her home or mother's	'Specialist' (privately engaged)	Private doctor	Private midwife	Nobody at all	All types of care
Total no. of mothers in each group	3875	323	946	120	1692	152	62	7170
Percentage of all mothers	54.0	4.5	13.2	1.7	23.6	2.1	0.9	100.0
71.7% (under supervision of Local Authorities and voluntary bodies)				27.4% (receiving care from private sources)			0.9% (receiving no care at all)	100.0%

The Ministry of Health collects each year, on Form M.C.W. 96, statistics of the number of women attending antenatal clinics (whether held at infant welfare centres or other premises) and the number receiving antenatal supervision through the General Practitioner scheme operated by many Local Authorities. It is of interest to compare the Ministry's figures¹ with the relevant percentages in Table 11. The figures from the two sources are very different; thus 58% of mothers in the Maternity Survey attended a clinic or came under the General Practitioner scheme as compared with 76% in the Ministry of Health's figures. The inclusion of Scotland in the Maternity Survey does not account for this difference, as its exclusion only results in raising the proportion attending clinics or coming under the General Practitioner scheme to 61%. The possibility cannot be excluded that some of the mothers who said they had only attended a midwife had omitted to mention a single clinic attendance. But the inclusion of all the mothers in this group would not raise the proportion to that found by the Ministry of Health, and, in fact, many of the

¹ *Summary Report of the Ministry of Health for the year ended 31 March 1945* (Cmd. 6710), p. 21.

mothers attended only by Municipal Midwives were in remote country districts where clinics were not available. A more likely reason for the disparity lies in the phrasing of the Ministry of Health's questionnaire. Each Authority is asked to give the 'total number of women who attended at the clinics [antenatal] during the year'. There is nothing in the phrasing to prevent mothers who attended several clinics of the same, or of different, Authorities being counted more than once. Such multiple attendances were often noted in the Maternity Survey, but in this case there was no possibility of multiple enumeration.

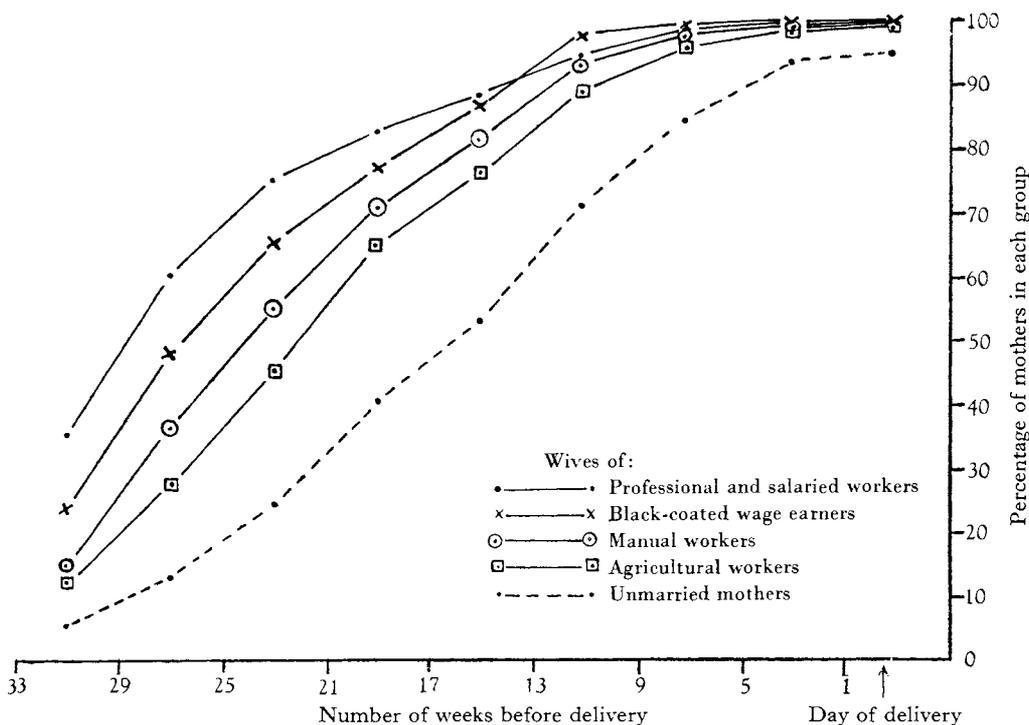


Fig. 1. Percentage of mothers who have come under antenatal supervision at different stages of pregnancy. (Separate curves for each occupational group).

The breakdown of type of antenatal care by occupational group shows the inter-group differences which were expected, namely, that the better-off mothers are more often supervised by their own private doctors than are the poorer.

Mothers were asked to say how long before delivery they first came under antenatal supervision. Their answers are analysed in Fig. 1, which shows the cumulative percentage of mothers who have come under antenatal supervision during each successive month of pregnancy. Separate curves are given for each occupational group. In interpreting these diagrams it should be remembered that hospital beds are usually booked when a mother first attends for antenatal care, and this, as well as the desire to obtain the extra rations available for pregnant women, must have been a strong incentive to early attendance.

The main differences between the occupational groups are found between the 33rd and 21st weeks before delivery. During this period a greater proportion of the better-off than of the poorer mothers have come under supervision. However, in all groups of married mothers antenatal care is first received relatively early in pregnancy. For unmarried mothers the position is less satisfactory: thus, 15% attended for the first time during the last 5 weeks of pregnancy as compared with 0.8% of married mothers.

Table 12 shows the mean number of weeks before delivery that mothers of different occupational groups first attended for antenatal care.

Table 12. *Date of first receiving antenatal supervision*

	Average date, in weeks before the delivery, of first antenatal attendances						
	Wives of					All un- married mothers	All occupa- tional groups
	Professional and salaried workers	Black- coated wage earners	Manual workers	Agri- cultural workers	Men in other occupa- tions		
Mean no. of weeks before delivery	25.5 ± 0.33	23.8 ± 0.27	21.7 ± 0.10	20.1 ± 0.51	22.5 ± 0.42	15.0 ± 0.47	21.9 ± 0.09

The majority of married mothers of all groups come under supervision during the fourth and fifth months of pregnancy; however, wives of professional and salaried workers first receive care on the average 4 weeks earlier than the wives of manual workers and 5 weeks earlier than the wives of agricultural workers. To this extent, at least, there is room both for further education of mothers in the importance of early antenatal attendances and for providing—especially in rural areas—more accessible facilities for antenatal care.

No detailed analysis has yet been made of the effects of work during pregnancy on antenatal attendance. However, such figures as are immediately available suggest that this factor is not one of great importance. Thus, mothers working full time at some period during pregnancy attended for antenatal care on the average 21.2 weeks before delivery, as compared to 22.1 weeks for all other groups of mothers.

6. *The confinement*

In this section a preliminary study is made of where the mothers were confined, who delivered them, what proportion were given analgesia or anaesthesia, how long they remained in hospitals or nursing homes, and the comments they made on their confinements.

(a) *The circumstances of confinement*

Confinements have been classified according to where they took place, namely, as (1) Domiciliary, (2) Hospital Public Ward (booked cases only), (3) Hospital (unbooked), (4) Hospital (private ward), (5) Nursing Home, (6) Elsewhere. These six categories will be referred to as the 'circumstances' of confinement.

The circumstances of confinement are shown, in Table 13, according to the occupational group.

Table 13. *Circumstances of confinement according to occupational group*

Circumstances of confinement	Wives of					All unmarried mothers	All occupational groups
	Professional and salaried workers	Black-coated wage earners	Manual workers	Agricultural workers	Men in other occupations		
Domiciliary (%)	23.4	35.7	51.3	57.2	49.1	39.7	46.7
Hospital (booked Public Ward) (%)	26.4	42.6	37.8	29.2	27.0	50.4	37.1
Hospital (unbooked) (%)	1.5	3.0	2.9	4.9	2.3	6.1	3.1
Hospital (private ward) (%)	10.0	2.5	1.3	2.3	3.3	0.8	2.3
Nursing home (%)	38.7	16.2	6.5	6.1	18.3	2.5	10.8
Elsewhere (%)	0.0	0.0	0.2	0.4	0.0	0.6	0.1
Total (%)	100.0	100.0	100.0	100.1	100.0	100.1	100.1
No. of mothers in each occupational group	599	765	4867	264	389	363	7247

It will be seen that institutional confinements are more frequent among the better-off than among the poorer mothers, and that all groups, except the wives of professional and salaried workers, have a smaller proportion of institutional confinements than the 70% that has been recommended as desirable.¹ The differences between the groups would appear to be largely due to the ability of the wealthier mothers to afford the heavy costs (see Table 28, p. 133) of nursing home confinements; but, apart from this, different preferences and differences in the age and parity composition of the groups are factors of importance.

The reasons given by each mother for choosing her place of confinement are analysed later in this section, and only the effects of parity will be studied here. It is generally thought advisable that all first births should take place in an institution,² and it is of interest to see how nearly this goal has been reached in each occupational group. Table 14 shows the proportion of institutional confinements among mothers grouped according to order of birth and husband's occupation.

Mothers in each group are more often confined in institutions for first, than for subsequent, births. In no group, however, are all first babies born in institutions.

For each birth order the proportion of institutional confinements falls with declining occupational status. However, the difference between the occupational groups is proportionately less for first than for subsequent births.

¹ *A National Maternity Service*, Report by the Maternity and Infant Health Services Committee of the Royal College of Obstetricians and Gynaecologists (1944), p. 27.

² *Infant Mortality in Scotland*, Sub-Committee of Scientific Advisory Committee, Department of Health for Scotland (1943), p. 66.

Table 14. *Institutional confinements analysed by order of birth and occupational group*

Order of birth	Percentage of confinements in hospitals and nursing homes among						
	Wives of					All unmarried mothers	All occupational groups
	Professional and salaried workers (%)	Black-coated wage earners (%)	Manual workers (%)	Agricultural workers (%)	Men in other occupations (%)		
First	85.2	75.8	64.1	67.0	72.7	64.0	67.8
Second or third	71.7	57.8	43.8	40.4	44.2	56.8	48.4
Fourth or higher	55.9	38.5	28.3	14.5	32.8	32.1	29.3

(b) Nature of person undertaking the delivery

Each mother was asked to say who actually delivered her. In classifying the answers to this question, it has not always been possible to check the correctness of the replies, and it is not certain that mothers have always made a clear differentiation between 'specialists' and doctors. There is a prestige value attached to attendance by a 'specialist', and, moreover, few mothers will have based their estimate of professional status on the possession of higher qualifications in obstetrics. Therefore, medical attendants may have been more often classified as 'specialists' than they should have been.¹ In the following paragraphs, therefore, the designation 'specialist' does not necessarily imply the possession of a higher qualification in obstetrics. When classifying midwives as Municipal or private, mothers are less likely to have made mistakes.

Table 15 shows the qualifications of the person actually undertaking the delivery of mothers. Domiciliary, hospital and nursing home confinements are treated separately.

Table 15. *Nature of person actually undertaking delivery according to circumstance of confinement*

Circumstance of confinement	Specialist (%)	Doctor (%)	Midwife (%)	Student (%)	Born before arrival of attendant (%)	Total (%)	No. of mothers in each circumstance
Domiciliary	0.2	18.8	67.6	5.3	8.0	99.9	3407
Hospital (booked public ward)	3.5	15.7	51.5	28.8	0.5	100.0	2633
Nursing home	8.1	57.3	33.9	0.0	0.7	100.0	762

3.1% of the domiciliary deliveries were carried out by doctors called in by midwives for emergencies. These have been included in the 18.8% of deliveries

¹ In fact, it does not seem likely that the incidence of specialist deliveries has been greatly over-estimated. There are 243 Fellows and 505 Members of the Royal College of Obstetricians and Gynaecologists, and in the week in which the survey was undertaken the total of deliveries by specialists in both Costs Survey and Maternity Services Survey was only 440.

by doctors of mothers confined at home. It is clear that confinement in hospital does not carry with it a greater likelihood of being delivered by a doctor than does confinement at home. Mothers confined in hospital are much more often delivered by students than mothers confined at home, but, on the other hand, their babies are very rarely born before the arrival of an attendant. Two-thirds of mothers confined in nursing homes are delivered by 'specialists' or doctors as compared with one-fifth of mothers confined in other circumstances.

A further analysis of the person delivering has been made on the basis of occupational group. It is found, in each circumstance of confinement, that poorer mothers are more often delivered by midwives than the better-off mothers. However, for institutional confinements, the differences are comparatively small, and presumably reflect regional differences in the staffing of maternity hospitals and nursing homes. For domiciliary confinements, as will be seen in Table 16, there are larger variations between the groups.

Table 16. *Nature of person actually undertaking the delivery of domiciliary confinements according to occupational group*

Person undertaking delivery	Among wives of					All unmarried mothers	All groups of mothers
	Professional and salaried workers	Black-coated wage earners	Manual workers	Agricultural workers	Men in other occupations		
'Specialist' or doctor (%)	46.4	28.6	15.5	25.2	27.7	18.2	19.0
Municipal Midwife (%)	32.9	52.0	61.5	58.2	55.8	61.5	59.1
Private Midwife (%)	11.4	7.3	9.3	4.0	5.3	3.5	8.5
Students (%)	3.6	6.2	5.6	0.0	4.3	4.9	5.2
Nobody (B.B.A.) (%)	5.7	5.9	8.1	12.6	6.9	11.2	8.1
Total (%)	100.0	100.0	100.0	100.0	100.0	99.3*	99.9
No. of mothers in each group	140	273	2496	151	181	143	3391

* One of the unmarried mothers was delivered by an unqualified person.

The main difference lies between the wives of professional and salaried workers, who are delivered by 'specialists' or doctors in 46.4% of home confinements, and the other groups of mothers, only 15-29% of whom are so delivered. This finding is of interest in relation to relief of pain during childbirth, which is discussed in the following subsection.

It will also be noticed that the proportion of unattended confinements increases in passing from the professional and salaried to the agricultural workers' group. The arrival after birth of a doctor or midwife is, of course, more likely to occur for second and higher order births than for first births. When standardized for birth order, the differences between the occupational groups disappear. Thus, 8.2% of domiciliary second and third births to wives of professional and salaried workers occur before the arrival of the attendant, as compared with 8.8% of similar births to wives of manual workers.

(c) Relief of pain during childbirth

Detailed inquiries were made to find out whether mothers had been given anything to relieve their pains during childbirth and, if so, what had been given. Each mother's answer was checked from the records of the doctor or midwife in attendance, if these were available. A great variety of types of analgesia and anaesthesia were recorded, varying from bromide draughts to spinal anaesthetics.

In this section, mothers have been classified as receiving (1) gas and air, (2) chloroform, (3) gas, air and chloroform, and (4) any other analgesic or anaesthetic (including trilene, twilight sleep, spinal anaesthetic and general anaesthetics). 39·7% of mothers received one of these four groups of analgesics or anaesthetics, and in addition some 6% were given bromide draughts, injections other than those mentioned above or medicines. These latter have been excluded from the mothers classified as being given analgesics or anaesthetics.

Table 17 shows how the type of analgesia or anaesthesia varies with the circumstances of confinement.

Table 17. *Type of analgesia and anaesthesia given classified by the circumstances of confinement*

Type of analgesia	Circumstances of confinement				
	Domiciliary	Hospital public ward	Hospital private ward	Nursing home	All circumstances
Gas and air (%)	25·8	69·8	35·1	21·0	47·3
Chloroform (%)	67·4	16·5	43·0	60·3	39·4
Gas, air and chloroform (%)	4·3	7·0	14·1	13·6	7·9
Other analgesic or general anaesthetic (%)	2·5	6·7	7·9	5·1	5·4
Total (%)	100·0	100·0	100·1	100·0	100·0
No. receiving analgesic or anaesthetic in each circumstance	717	1406	128	552	2803

Two-thirds of the mothers receiving analgesia or anaesthesia during home confinements are delivered by general practitioners who in nearly every case give them chloroform. Gas and air is comparatively rarely used in domiciliary practice, but its use is likely to become more frequent now that portable gas and air apparatus are becoming available and more midwives are being trained in their use; and now that midwives have less stringent regulations to comply with when they administer analgesia.¹

Chloroform, as an analgesic, is more favoured in nursing homes than in hospitals, a difference in practice which is to be associated with the comparatively large proportion of nursing home deliveries undertaken by general practitioners.

¹ The Central Midwives Board has decided to make training in administration of analgesia compulsory for all pupil midwives entering Part II Training Schools after 1 July 1946. Section 3 of the regulations of the Board has been amended so that analgesia may be now administered by a midwife provided that 'one other person, being any person acceptable to the patient, who in the opinion of the midwife is suitable for the purpose, is present at the time of administration in addition to the midwife in charge of the case'.

Table 18 shows how the proportion of mothers receiving analgesia varies with occupational group and circumstances of confinement.

Table 18. *Proportion of mothers receiving analgesia or anaesthesia according to occupational group and circumstances of confinement*

Circumstance of confinement	Proportion of confinements in which analgesia or anaesthesia was given among						
	Wives of					All unmarried mothers (%)	All occupational groups (%)
	Pro-fessional and salaried workers (%)	Black-coated wage earners (%)	Manual workers (%)	Agri-cultural workers (%)	Men in other occupations (%)		
Domiciliary	55.8	31.1	17.8	22.0	28.3	15.4	21.1
Hospital (booked public ward)	69.8	58.9	50.2	42.7	64.8	42.4	51.9
Hospital (private ward)	88.5	73.5	68.9	83.1	*	*	77.0
Nursing home	77.5	74.0	68.0	43.7	64.8	*	71.1
All circumstances	72.8	51.6	34.6	31.2	48.5	30.8	39.7

* Only a few mothers in each group.

In each circumstance of confinement, wives of professional and salaried workers are more often given analgesia or anaesthesia than any other group. This difference is most marked in home confinements, when 56% receive analgesia or anaesthesia as compared with 18% of wives of manual workers. This is to be associated with the high proportion of 'specialist' or practitioner deliveries in the higher income group. However, in hospital public ward confinements, also, mothers of this group are given analgesia or anaesthesia more frequently than any others. In this case, the difference may arise from their more insistent demands for relief from pain. It will be shown, later in this section, that they are more critical about all aspects of their confinement (even analgesia) than the poorer mothers.

It is not yet possible to make a regional analysis of the proportion of mothers given analgesia or anaesthesia. This will, however, be done in a subsequent publication.

(d) *Length of stay in hospitals and nursing homes*

Each woman confined in hospital or nursing home was asked how many days after delivery she had been discharged. Curves of the cumulative percentages of mothers who have been discharged on each successive day after delivery are shown for hospital and nursing home confinements in Fig. 2.

Before the 14th day, a considerably smaller proportion of mothers are discharged from nursing homes than from hospitals. Thus, on the 11th day after delivery, only 10% of mothers confined in nursing homes have left as compared with 42% of the hospitalized. It is during the first 14 days (the lying-in period) that it is most desirable that mothers should remain in institutions, as there is little doubt that as soon as they leave they will take up household duties. From this point of view,

therefore, mothers confined in nursing homes are in a more favourable position than those confined in hospital.

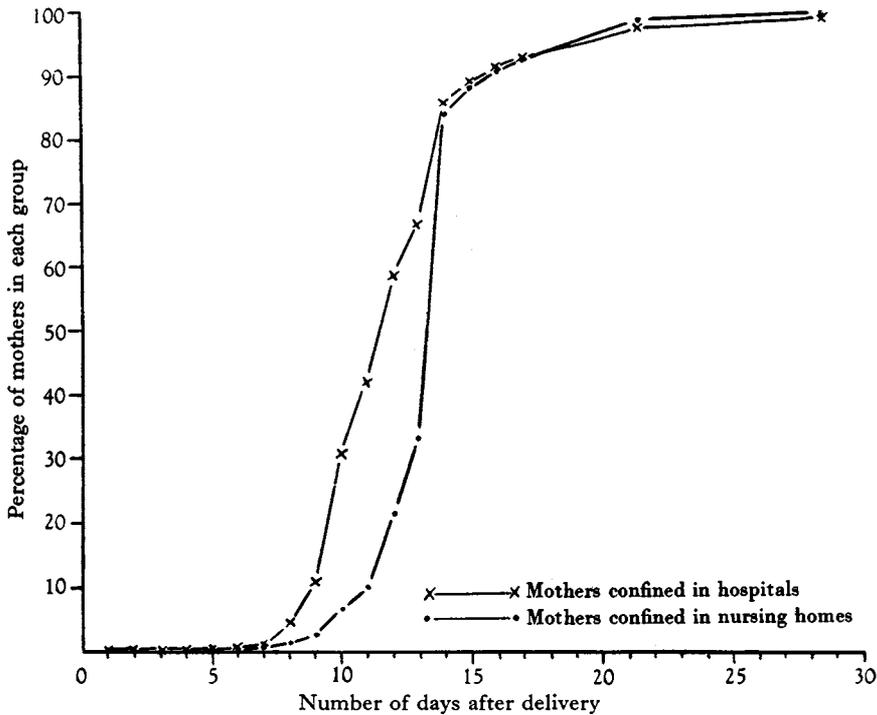


Fig. 2. Percentage of mothers who, on each day after delivery, have left hospital or nursing home.

Table 19 shows the mean number of days after delivery that mothers were discharged from institutions. Separate figures are given for each occupational group, and for hospitals and nursing homes.

Table 19. Mean length of stay in hospital or nursing home according to occupational group of mother

Circumstance of confinement	Average days after birth that discharge was taken by						
	Wives of					All unmarried mothers	All occupational groups
	Professional and salaried workers	Black-coated wage earners	Manual workers	Agricultural workers	Men in other occupations		
Hospital (booked public ward)	13.4 ± 0.41	12.9 ± 0.21	12.5 ± 0.11	13.1 ± 0.40	13.2 ± 0.31	16.1 ± 0.97	12.9 ± 0.11
Nursing home	14.6 ± 0.25	13.3 ± 0.23	13.7 ± 0.19	*	*	*	14.2 ± 0.17

* Only a few mothers in each group.

In each place of confinement, the more prosperous mothers stay slightly longer than the poorer. The difference is most marked before the 14th day. Thus, by the

end of the 11th day, 46% of manual workers' wives have left hospital as compared with 31% of wives of professional and salaried workers. If we assume that discharge before the end of the lying-in period is an index of the shortage of maternity beds, it will be seen that the effects of the shortage are felt more by mothers confined in hospital than in nursing homes, and that the poorer are rather more affected than the better-off.

(e) *Comments on the confinement*

Mothers were asked to comment freely on why they chose their place of confinement, and to state any complaints they had about treatment during confinement. The Health Visitors were asked to record each answer in the mother's own words.

It is difficult to assess the value of comments such as these. The possibility of serious bias from prejudiced recording by an occasional interviewer has been eliminated by the large number of Health Visitors taking part. But it may be argued that the mothers' comments give the opinions of the Health Visitors as a class rather than of the mothers into whose mouths they have been put. This argument cannot be disproved, but a careful examination of the content and phrasing of the comments suggests that the majority are accurate transcriptions of what each mother said. A further objection, which can neither be proved nor disproved, is that the mothers said what would please the Health Visitors, and not what they themselves felt.

Of the two groups of comments considered here, those giving the reason for choosing the place of confinement are less likely to be distorted by the types of bias discussed in the previous paragraph. Health Visitors must have a shrewd knowledge of the conditions that lead to home or institutional confinement, so that comments will be of value even if they represent the opinions of the Health Visitors rather than of the mothers. Unfortunately, this argument is not applicable to the other comments which must be regarded, at least until further analysis is possible, as of limited value.

Reasons for choosing places of confinement. The reasons given by mothers for choosing their place of confinement are shown in Table 20. 92% of mothers replied to this question.

Table 20. *Mother's reasons for choosing her place of confinement*

Circumstance of confinement	Preference (%)	No vacancies elsewhere (%)	Home unsuitable (%)	No help in house	To be near family (%)	Medical advice (%)	Feels safer (%)	Other reasons (%)	Total (%)	No. answering
Domiciliary	50.2	12.9	2.2*	16.0	8.2	0.8	3.5	6.3	100.1	2995
Hospital (booked public ward)	16.6	2.8	34.9	11.7	0.6	21.3	11.3	0.8	100.0	2549
Nursing home	29.3	10.4	25.4	15.0	1.0	10.4	7.9	0.7	100.1	713

* These domiciliary confinements were in the homes of the mother's relations or friends and not in their own homes.

The reasons for being confined at home are very different from those for being confined in institutions. Preference is the major reason given for home confinement, whereas a much smaller proportion of mothers said that they preferred to be confined in an institution.

A further analysis has been made according to birth order. The reasons given for being confined at home were greatly affected by the number of children born to each mother; on the other hand, the reason for hospital confinement did not appear to be influenced by this factor. Thus, 57% of primiparous mothers were confined at home by preference, as compared with only 39% of mothers having their fourth or later confinements. It is the necessity to look after the other children in the family that keeps multiparous mothers at home for their confinements. Lack of help in the home is given as a reason for home confinement by only 1% of primiparous mothers, but this proportion rises sharply with increasing birth order, being 10% for second births, 22% for third and 34% for all higher orders. Many of the comments of mothers confined at home because they could not get domestic help, give the impression that they not only directed but also undertook domestic duties from within a few days of delivery.

Shortage of hospital and nursing home beds is given as a reason for home confinement by many fewer mothers than had been expected.

Unsuitable home conditions account for the largest proportion of hospital and a large proportion of nursing home confinements, and medical advice and lack of domestic help are also important causes. Some of the hospital patients would have gone to a nursing home if they could, but a larger proportion of the nursing home patients would have preferred a hospital confinement. In general, then, it would appear from these reported comments that mothers are confined at home from choice and in institutions from necessity.

The reasons have been analysed according to occupational group. For domiciliary confinements, it is of interest that 68% of the wives of agricultural workers preferred to be at home as compared with 45-48% of wives in other groups. For confinements in hospitals and nursing homes similar reasons were advanced by mothers in all occupational groups.

Complaints. Each mother was asked whether anything more could have been done to make her delivery satisfactory. The majority in all groups said that they were quite satisfied. Wives of professional and salaried workers were always the most critical, and unmarried mothers the least so. Insufficient analgesia was the most frequent complaint, and here, again, it was the wives of professional and salaried workers that were the most vocal, although, as has been seen above, they had the least cause to complain. Lack of help in the home was the second most frequent complaint, made, especially, by wives of agricultural workers.

7. *Postnatal care of mothers and their babies*

Postnatal examination by a doctor or specialist. At the time of interview, 8 weeks after delivery, the majority of mothers who intended to have a postnatal examination should have had it. Each mother was therefore asked whether she had been

examined by a doctor or specialist since delivery. In interpreting the answers to this question, it has been impossible to make any assessment of how thorough an examination had been carried out. There is little doubt that many of the mothers answered affirmatively when they had been examined in a most superficial manner, and the 31% of mothers who said that they had been given a postnatal examination by a doctor or specialist should be regarded as an overestimate.

The proportion of mothers examined varies considerably with where they are confined, how many previous children have been born to them, and the type of antenatal care they have received. The most important of these three factors is the place of confinement. Thus, after standardizing for birth order and type of antenatal care, it is found that the proportions of postnatal examinations are 39% for hospital, 28% for nursing home, and 17% for home, confinements. Birth order is the next most important factor, postnatal examinations being given to 32% of primiparous as compared with only 22% of those who have borne three or more previous children. After standardizing for birth order and circumstance of delivery it is found that the type of antenatal care is a factor of little importance; however, mothers supervised during pregnancy by their own private doctor are rather more frequently examined postnatally than those receiving antenatal care from other sources.

The occupational group of the mother is not a factor which greatly influences the incidence of postnatal examinations. Wives of professional and salaried workers are indeed more frequently examined, but this is mainly due to the high proportion of first births, institutional deliveries, and antenatal supervision by private doctors, found among the mothers in this group.

Under the most favourable conditions (that is, first births delivered in hospital) only 48% are given a postnatal examination and, when it is considered that even this figure is probably an overestimate, the present position of postnatal examinations appears to leave much to be desired.

Infant Welfare Centres. In considering the data collected on attendances at Infant Welfare Centres, it is necessary to remember that at the date of interview many mothers would not yet have had time, nor have been persuaded, to attend Infant Welfare Centres. Mothers who were not taking their babies to Infant Welfare Centres were therefore asked whether they intended to do so. Those that did not intend to take their babies were then asked their reasons.

It was shown, in a recent survey of the maternity services in Middlesbrough,¹ that three factors are of major importance in determining whether or not a mother takes her baby to an Infant Welfare Centre. These are, whether she is confined at home or in hospital, whether she goes to an antenatal clinic, and the number of previous children she has borne. The relative importance of these three factors is studied in the following paragraphs which fully substantiate the findings of the Middlesbrough report.

¹ *Maternity Services in Middlesbrough*, Griselda Rowntree, Association for Planning and Regional Reconstruction (1946), Report R. 40. (This is a preliminary report of part of a Social Survey carried out under the direction of Ruth Glass.)

57% of all mothers had started to take their babies to Infant Welfare Centres within 8 weeks of delivery. After standardizing for place of confinement and birth order, it is found that the proportion attending at Infant Welfare Centres is greatest (66%) when mothers have previously attended an antenatal clinic, and least (44%) when they have been given antenatal supervision by their own private doctors or private midwives. An intermediate position is occupied by mothers supervised during pregnancy by Municipal Midwives or coming under the General Practitioner scheme; 50% of these made use of the Centre Services.

After standardizing for type of antenatal care and birth order it is found that a greater proportion of mothers confined in hospital than in any other circumstance attend Infant Welfare Centres. The proportions are 64% of those confined in hospital, 54% of those confined at home and 46% of those confined in nursing homes.

Birth order has a comparatively small effect, after the influence of place of confinement and type of antenatal supervision have been eliminated, except in the case of mothers with large families of four or more children. The proportion of these latter taking their babies to the Infant Welfare Centres is 44% as compared with 60% of mothers of one, two or three children. Presumably it is lack of time that prevents the mothers of large families from attending.

The mothers with the highest proportion of infant welfare attendances are primiparous women who have attended antenatal clinics and been confined in hospital. Of these, 75% take their babies to the centre during the first 8 weeks after delivery.

The figures in the above paragraphs suggest that, both during her antenatal clinic attendances, and during her confinement in hospital, a mother is given more effective education in the value of the Infant Welfare Service than if she had received other types of antenatal care, or been confined in her own home or a private nursing home.

Table 21 shows the proportion of mothers in each group who were receiving advice on the care of their children either at Infant Welfare Centres or from other sources. Mothers who said that they intended in the future to use the Centre Services, and mothers who did not intend to do so but made no mention of alternative medical care, have been grouped together. It is probable that many mothers in this group are either receiving or will receive advice from some qualified source on the care of their babies.

Ministry of Health records¹ for England and Wales show first attendances of children under 1 year of age at Infant Welfare Centres as 71% of all notified live births. This is considerably more than the figure of 57% found in this survey for mothers actually taking their babies to Infant Welfare Centres. However, a further 26% of mothers said that they intended to use the Centres (a proportion included in Table 22 as part of the category of those not yet attending), so that the proportion of mothers using, or who say they are prepared to use, the Centre Services

¹ *Summary Report of the Ministry of Health for the year ended 31 March 1945* (Cmd. 6710), p. 21.

is some 12% higher than the Ministry's figure for actual attendances of children under 1 year.

Table 21. *Proportion of mothers being advised on the care of their babies*

Mothers who were	Wives of					All unmarried mothers	All occupational groups
	Professional and salaried workers	Black-coated wage earners	Manual workers	Agricultural workers	Men in other occupations		
Taking baby to I.W.C. (%)	44.5	62.5	61.5	31.5	39.4	43.8	57.1
Receiving medical advice from other sources (%)	17.6	3.4	2.5	4.4	10.0	7.2	4.6
Not yet using I.W.C. (%) (No information as to alternative care)	37.9	34.1	36.0	64.1	50.6	49.0	38.3
Total (%)	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of mothers in each group	569	715	4570	245	370	333	6802

8. *Expenditure on childbearing*

(a) *Introduction*

The expenditure associated with the birth of a baby, quite apart from the subsequent maintenance of the child, is a financial burden which for many families is likely to be a deterrent to parenthood. In spite of its importance from this point of view, no detailed investigation of the extent and nature of the costs of childbearing has previously been carried out on a national scale. Surveys of family expenditure have generally studied long-term maintenance costs, rather than the extraordinary expenditure arising from such family events as childbirth. These studies have shown an inverse correlation between family size and income, but have scarcely mentioned the specific and immediate impact on the household budget of an addition to the family.

The detailed study of the economic aspects of childbearing, described below, provides some of the basic information necessary for formulating a population programme. The analysis of actual expenditure on particular items of cost shows where grants, subsidies and other forms of assistance are likely to prove of greatest help.

The aim of this part of the investigation was to obtain from every mother interviewed a statement of the amount of money she had had to spend on medical costs and other specified items connected with the birth of her child. The original cost of borrowed or 'handed down' clothes or prams was excluded from the budget, which was limited to actual payments by the mother for this birth alone. For this reason, and because only specified costs were considered, the figures below represent minimum expenditure.

The Cost Survey was undertaken during the period of wartime controlled economy. Rationing and price control were in full operation, and second-hand goods were scarce and costly. These circumstances would tend to minimize differences between the expenditures of mothers of different occupational groups. It seems probable that, in 'normal' times, the upper social groups would spend more, and perhaps the lower groups would spend somewhat less, than the results of the present inquiry suggest. Nevertheless, these results give a substantially accurate picture of the levels of the various costs involved.

(b) *Methods*

The questions on expenditure were set out in five tables, with instructions that the cost of each item should be entered separately in pounds and shillings. Further, the Health Visitors were particularly requested to exclude the outlay on any items other than those listed in the tables.

On the first table were to be entered the fees (after assessment and before deduction of benefit) of the midwife, the doctor and the hospital and nursing home charges. If these were not separately known, an inclusive payment could be entered. Entries were also made in this table of payments for resident maternity nurses, ambulances and extra help in the house.

In the other four tables separate costs were given for each item, but only total costs in each table have been analysed. The second table asked for the separate costs of extra laundry, chemists' bills, sterilized outfits and anaesthetics. The third table contained a list of fourteen items of baby clothes,¹ requiring a statement of the number bought of each kind, as well as the price, and the fourth table listed in a similar fashion the costs of seven categories of maternity garments.² Finally, the fifth table asked for the costs of the pram, cot, baby's bath, and carry cot.

By this method, the costs of a wide, but specified, range of items connected with the present pregnancy and confinement were obtained, and precautions were taken to ensure that the expenditure of each mother was strictly comparable with that of every other.

In coding the answers to the Cost Survey, the cost of each item entered in the second, third, fourth and fifth tables was checked. Improbable entries were queried by a letter to the Medical Officer of Health concerned, or compared with retailers' price lists. The subtotals and the separate medical and institutional fees were then coded to the nearest £ in value. Finally, all the costs of each mother were totalled and entered on the questionnaire.

A total of only twenty-seven mothers either refused, or were unable, to answer any questions on expenditure, although they completed the rest of the questionnaire. They have been entirely excluded from the following analysis.

¹ Napkins, vests, petticoats, nightgowns, dresses, knickers or pilches, matinee coats, pairs of bootees, pairs of leggings, pairs of gloves, bonnets, shawls, rubber sheets, bedding for the pram and cot.

² Smocks, skirts and dresses, nightdresses, coats, dressing gowns, corsets and brassieres, and knickers.

(c) The response to questions on expenditure

Almost all the 6,400 mothers who gave complete answers in other parts of the Cost Survey, provided information on their expenditure as well. The mothers who recorded fully all items of cost, and those who were unable to state completely the amount of their medical and institutional fees, are shown in Table 22 as a proportion of the total numbers in each occupational group. Wives who did not disclose their husbands' occupations are included here, but omitted from subsequent tables.

Table 22. *Response to questions on expenditure according to occupational group*

Type of response	Wives of						All un- married mothers	All groups
	Pro- fessional and salaried workers	Black- coated wage earners	Manual workers	Agri- cultural workers	Men in other occupa- tions	Men in unknown occupa- tions		
All items of expendi- ture recorded (%)	80.6	85.8	87.0	88.9	83.8	91.8	85.3	86.1
One or more items of expenditure omitted (%)	19.3	14.2	13.0	11.1	16.2	8.3	14.7	13.8
Total (%)	99.9	100.0	100.0	100.0	100.0	100.1	100.0	99.9
No. of cases	527	676	4118	306	398	36	312	6373
No. of cases not recording expenditure								27
Grand total								6400

Mothers in the professional and salaried, and in the 'other occupations' groups more often omitted to give some items of cost than those in the remaining groups. This may be due to unpaid doctors' fees for which the well-to-do mothers had not received bills by the date of interview.

There were only small differences in the average outlay of mothers giving full details, and mothers giving incomplete details, on expenditure. Both types of mothers have therefore been combined in all the following tables.

(d) Expenditure on all items

A total of 6,337 mothers of known occupational status recorded information on expenditure. This figure includes 312 unmarried mothers, but as they have special economic and domestic problems and frequently receive free institutional care, it is difficult to make a significant comparison between their expenditure and that of married mothers. The group of unmarried mothers has therefore been separated from the rest, and their recorded expenditure is briefly discussed at the end of this section.

The percentage distribution of mothers, according to the level of their total recorded expenditure on childbearing, is shown in Figs. 3 and 4. Fig. 3 is concerned with the costs associated with first births, and separate curves are shown for three occupational groups, viz. the wives of professional and salaried workers, of manual workers and of agricultural workers. The other occupational groups, which

take up an intermediate position between those of the professional and salaried and the manual workers, have been omitted for the sake of clarity.

This distribution shows a marked difference in the levels of expenditure of the various occupational groups. The curve showing agricultural workers' wives according to their expenditure has a smaller range than the other curves. The modal sum spent by mothers in this group is £22 as compared with £32 by wives of manual workers and £47 by wives of professional and salaried workers. Most wives of the agricultural workers spend between £10 and £40. A curve of similar

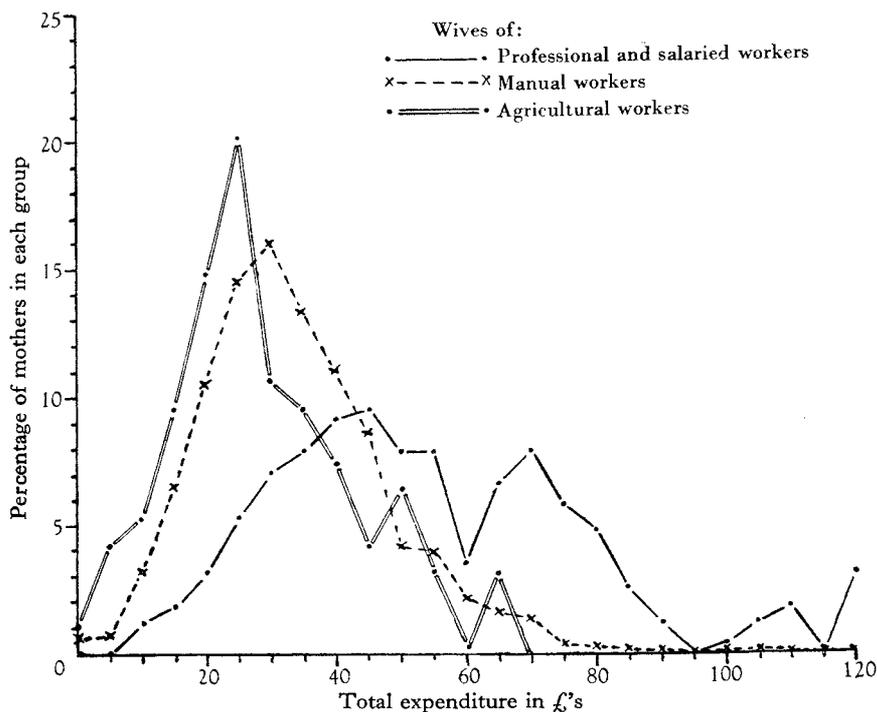


Fig. 3. Percentage distribution of primiparous mothers according to the total amount spent. (Three occupational groups only.)

shape but rather more dispersed is given for the manual workers' group, and this contrasts sharply with the much flatter curve for the professional and salaried group, of whom only very few spend less than £20 and quite a high proportion spend more than £60.

A similar percentage distribution according to total outlay is shown for multiparous mothers of the three occupational groups in Fig. 4.

Comparing this with the previous figure, it is clear that less is spent on subsequent births than on first births in every group. The range of the curves for manual and agricultural workers' wives is less, and very few in these groups spend more than £40. Many wives of professional and salaried workers still pay very large sums, however, and the contrast between the curve of this group and the curves of the working-class groups is even greater for subsequent births than it was

for first births. To summarize, only the well-to-do mothers spend very large amounts on pregnancy and childbirth.¹ On the other hand, many of the poorer mothers spend quite substantial sums, especially on first births.

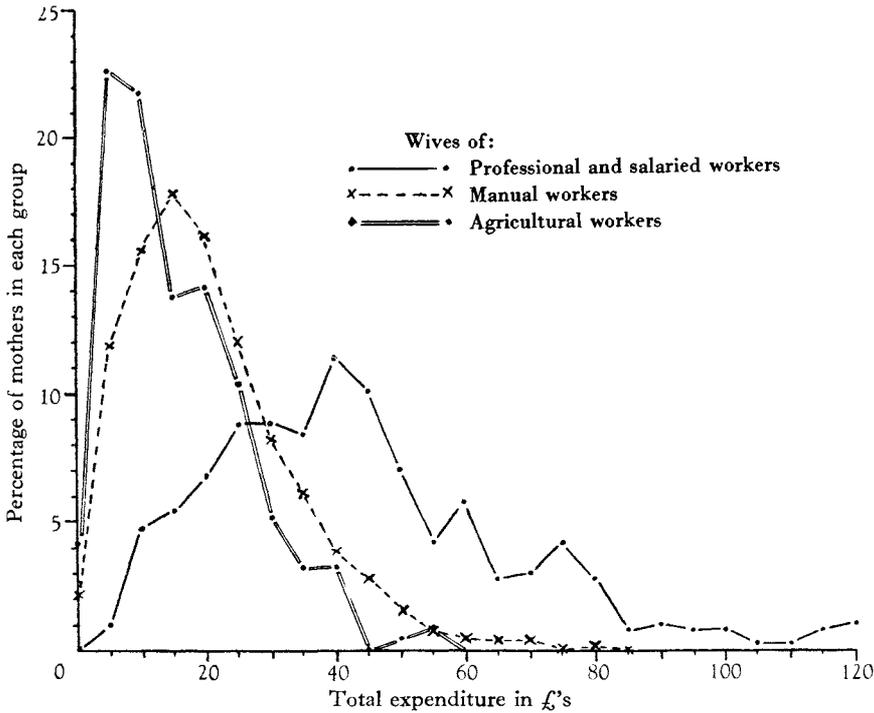


Fig. 4. Percentage distribution of multiparous mothers according to the total amount spent. (Three occupational groups only.)

The average outlay of all married mothers in the sample is £32. Average expenditures of mothers in the different occupational groups deviate widely from the overall mean. Table 23 shows the average expenditure, at first and at subsequent births, of mothers in each group.

Table 23. Average expenditure of the occupational groups on first and subsequent births

Order of birth	Expenditure of wives of					All married mothers £
	Professional and salaried workers £	Black-coated wage earners £	Manual workers £	Agricultural workers £	Men in other occupations £	
First	57.0 ± 1.78	44.4 ± 0.98	35.6 ± 0.38	31.6 ± 1.47	47.5 ± 1.93	39.5 ± 0.39
Subsequent	46.4 ± 1.40	30.0 ± 0.80	24.1 ± 0.26	17.5 ± 0.75	35.2 ± 1.41	27.1 ± 0.28

¹ A total outlay of more than £100 was made by 43 mothers, the highest individual expenditure being £296.

This table shows the heavy expenditure on childbirth incurred by families of every occupational group. Expenditure, it is true, decreases with the decline in status, but this decrease is scarcely proportional to the income differences between the groups. Mothers in the professional and salaried group spend on their first children almost twice as much as do wives of agricultural workers, the outlay of the other groups falling within these limits. This differentiation is even sharper for subsequent births. It will be noted that each group spends less on later births in the family than on the first.

Average expenditure on each order of birth by the different occupational groups is given in Table 24.

Table 24. *Total expenditure according to order of birth and occupational group*

Order of birth	Average expenditure of wives of					All married mothers £
	Professional and salaried workers £	Black-coated wage earners £	Manual workers £	Agricultural workers £	Men in other occupations £	
First	57.0	44.4	35.6	31.6	47.5	39.5
Second	45.5	31.8	25.4	19.3	39.1	29.1
Third	47.4	30.5	22.7	18.4	32.8	25.8
Fourth	52.3	21.6	20.3	16.2	28.3	22.4
Fifth or higher	39.5	23.1	15.9	13.9	31.8	17.6

Decreasing expenditure with increasing parity is shown to be the rule for each group, except the professional and salaried, who spend more on their third than they do on their second, births. In all groups the greatest differences in expenditure are between first and second births, presumably because most mothers use for their subsequent children clothes and equipment 'passed down' from the first child. The pressure of successive births on the limited incomes of the less prosperous families is even more clearly shown in Table 25. This table, derived from Table 24, gives the outlay of the poorer occupational groups in each order of birth, expressed as a proportion of the expenditure of the professional and salaried group.

Table 25. *Total expenditure of some poorer occupational groups as a proportion of the total expenditure of the professional and salaried group for each order of birth*

Order of birth	Proportional expenditure of wives of			
	Professional and salaried workers	Black-coated wage earners	Manual workers	Agricultural workers
First	100	78	63	55
Second	100	70	56	47
Third	100	64	48	39
Fourth	100	41	39	31

Differences in the expenditures of the groups increase markedly with parity. Thus, the agricultural workers' group spends on first births about half as much as the professional and salaried, but on fourth births they spend only one-third as much.

(e) *Expenditure on individual items*

Medical and institutional fees. Separate tabulations for the costs of medical advice, of obstetric care and of hospital or nursing home treatment are not yet available, and these items are therefore grouped into the one category of 'medical and institutional fees'. Table 26 shows average expenditure on these fees for each occupational group.

Table 26. *Average medical and institutional fees of the occupational groups*

Order of birth	Average expenditure of wives of					All married mothers £
	Pro- fessional and salaried workers £	Black- coated wage earners £	Manual workers £	Agri- cultural workers £	Men in other occu- pations £	
First	17.5	9.3	5.9	5.8	12.8	7.9
Subsequent	16.4	6.8	4.2	3.4	9.2	5.9

The amount spent on medical and institutional fees decreases with the status of the group. The professional and salaried group spend on first births twice as much as the black-coated group, and about three times as much as either the manual or the agricultural workers' groups. In each group more is paid for first than for subsequent births, the difference being proportionately greatest for the agricultural workers.

These differences in expenditure are largely to be explained by the greater proportion of well-to-do mothers being confined in nursing homes.¹ Table 27 shows for all groups combined the average expenditure on medical and institutional fees according to the place of confinement.

Table 27. *Circumstances of confinement and expenditure on medical and institutional fees*

Order of birth	Average expenditure by mothers confined in			
	Nursing home £	Hospital (booked public ward) £	Own home £	Total £
First	22.8	5.1	3.5	7.9
Subsequent	20.9	4.9	2.9	5.9
All	21.9	5.0	3.1	6.1

Mothers confined in nursing homes spend on the average seven times as much as mothers confined at home, and four times as much as mothers using the public wards of hospitals.

¹ In the Cost Survey the proportion of nursing home to total confinements is 39.8%, 16.8% and 7.1% for the professional and salaried, the black-coated and the manual workers' groups respectively. See also § 6.

Table 28 gives the average expenditure on medical and institutional fees, according to the place of confinement, for the professional and salaried, the black-coated, and the manual workers' groups separately.

Table 28. *Average expenditure on medical and institutional fees for each place of confinement*

	Average expenditure of wives of		
	Professional and salaried workers £	Black-coated wage earners £	Manual workers £
First births:			
In nursing homes	27.3	21.4	20.1
In hospitals	8.2	5.8	4.9
At home	5.7	4.1	3.3
Subsequent births:			
In nursing homes	26.5	18.2	16.4
In hospitals	9.3	5.6	4.3
At home	6.1	3.8	2.5

Expenditure on medical and institutional fees is in each circumstance of delivery highest for the professional and salaried group and lowest for the manual workers. This is to be explained by differences in the quality of the nursing homes and the length of time the mothers stay in them, by differential expenditure on specialist and private doctors' fees, and by Local Authority schemes of differential assessment of hospital charges and midwives' fees for the different income groups.

Other confinement costs. The combined average expenditure on extra help of every kind, and also the cost of medicines and anaesthetics, is shown in Table 29 for mothers in each occupational group.

Table 29. *Other confinement costs for first and subsequent births*

Order of birth	Average expenditure of wives of					All married mothers £
	Professional and salaried workers £	Black-coated wage earners £	Manual workers £	Agricultural workers £	Men in other occupations £	
First	3.3	2.0	1.7	2.2	2.2	2.0
Subsequent	6.8	2.7	2.4	2.2	4.6	3.1

Average outlay on these costs is small, except in the professional and salaried group. But it is perhaps rather misleading to state these costs as an average, since many mothers pay nothing at all, whereas a few are involved in high expenditure. For example, very high costs are incurred by mothers of the professional and salaried group who are confined at home and employ resident maternity nurses. The wives of farmers, also, are often involved at the end of pregnancy in considerable expenses in engaging substitutes to take over their work on the farm. This is the only type of expenditure in which more is paid for subsequent births than for

first births. It is mainly due to the need for employing extra help to look after the children, at least during confinement.

The cost of clothing and equipment. This type of expenditure includes outlay on special maternity garments worn during pregnancy, the cost of baby clothes and the cost of the pram, cot and the bath. Average expenditure on these different kinds of articles by the mothers in each occupational group is shown in Table 30.

Table 30. *Average expenditure on maternity garments, baby clothes and equipment*

Cost of	Expenditure of wives of					All married mothers £
	Pro- fessional and salaried workers £	Black- coated wage earners £	Manual workers £	Agri- cultural workers £	Men in other occupa- tions £	
Maternity garments:						
First births	10.8	8.5	6.6	4.6	8.7	7.3
Subsequent births	7.6	5.4	4.3	2.8	6.1	4.7
Baby clothes:						
First births	11.0	11.2	10.1	9.3	10.5	10.3
Subsequent births	7.4	7.3	6.9	4.8	7.4	6.9
Prams, cots, etc.:						
First births	14.4	13.4	11.3	9.7	13.3	12.0
Subsequent births	8.2	7.8	6.3	4.3	7.9	6.6

The outlay made at the birth of a first child stands at a high figure in every group. Married primiparous mothers pay almost £30 on all items taken together. The corresponding expenditure on later births is much less, being in the region of £18. The large differences between the sums spent on first and on subsequent births in every occupational group may be in part due to shortage of these goods and to clothes rationing. Mothers can only buy the minimum of articles they require, and clothes and equipment bought at the birth of a previous child are used again.

The equalizing effects of rationing and price-fixing are seen in the expenditure of different occupational groups on baby clothes and prams. These items are essential, and in order to obtain them at all, wives of manual workers have to pay almost as much as wives of professional and salaried men, i.e. £21 as compared with £25 for first births.¹

The distribution of expenditure among the different items of cost. The proportion of the total outlay spent on each item of cost is shown for each occupational group in Table 31.

The professional and salaried workers' wives spend relatively about twice as much on medical and institutional fees as manual workers' wives, and the relative expenditures of the other groups lies between these extremes. But this situation is reversed when it comes to expenditure on clothing, prams and cots. Poorer mothers

¹ It is interesting that agricultural workers' wives spend considerably less than manual workers' wives on these items. That may well be due to a greater amount of borrowing of clothes and equipment among the low-income groups in stable rural communities.

spend three-quarters of their outlay on necessary clothes and equipment but well-to-do mothers spend less than two-thirds of their total outlay on these goods for first births, and only one-half for later births. The greatest disparities between the groups occur in the relative outlay on baby clothes and on prams and cots.

Table 31. *Proportion of total outlay spent on various items of expenditure*

	Total outlay of wives of					All married mothers %
	Professional and salaried workers %	Black-coated wage earners %	Manual workers %	Agricultural workers %	Men in other occupations %	
First births:						
Medical and institutional fees	30.7	21.0	16.4	18.4	26.9	19.9
Other confinement costs	5.7	4.4	5.0	6.9	4.6	5.0
Cost of maternity garments	19.0	19.2	18.5	14.6	18.3	18.5
Cost of baby clothes	19.4	25.2	28.2	29.2	22.1	26.1
Cost of prams, cots, etc.	25.3	30.1	31.8	30.8	28.0	30.4
Total	100.1	99.9	99.9	99.9	99.9	99.9
Subsequent births:						
Medical and institutional fees	35.3	22.5	17.5	19.3	26.2	21.6
Other confinement costs	14.8	9.1	10.0	12.7	13.2	11.0
Cost of maternity garments	16.4	18.0	17.7	16.3	17.4	17.5
Cost of baby clothes	15.8	24.5	28.6	27.4	21.0	25.5
Cost of prams, cots, etc.	17.6	25.9	26.2	24.3	22.3	24.5
Total	99.9	100.0	100.0	100.0	100.1	100.1

(f) *The expenditure of unmarried mothers*

Unmarried mothers have special problems connected with low income, the concealment of pregnancy and, often, the absence of preparations for confinement. Many of their costs, however, may be met by Public Assistance Authorities or charitable organizations, and these are not included in the mothers' statement of outlay. Table 32 gives the average recorded expenditure of unmarried mothers on different types of cost, as well as the total outlay. It also shows the expenditures of manual and agricultural workers combined, and the average expenditure of all married mothers. Only first births are considered.

Table 32. *Average expenditure of unmarried mothers compared with married mothers. First births only*

	Average expenditure on					Total £
	Medical and institutional fees £	Other confinement costs £	Maternity garments £	Baby clothes £	Prams, cots, etc. £	
Unmarried mothers	3.4	0.7	2.6	5.7	4.7	17.2
Wives of manual and agricultural workers	5.9	1.8	6.5	10.0	11.2	35.4
All married mothers	7.9	2.0	7.3	10.3	12.0	39.5

The recorded expenditure of unmarried mothers is approximately only half that of the working class groups. This is true for all items.

(g) *Discussion*

This study, although incomplete, has shown the high cost of childbearing. The lower social groups spend in actual figures less than the more prosperous. However, in proportion to total income, the working-class family is almost certainly paying much more. The birth of a baby in many poorer families—even when they have been fully assessed for the medical costs of the confinement—must mean that the family budget can only be balanced by borrowing or drawing on savings. It has been said that children are ‘the chief cause of poverty’, and this inquiry shows that the drain of family expenditure begins sharply at the birth of the first child. The various forms of assistance to mothers, such as maternity grants and prenatal allowances for servicemen’s wives, go only a little way towards reimbursing this expenditure. The major outlay, especially in the poorer groups, is made in buying essential clothes and equipment rather than in paying medical and institutional fees. The possibility of bringing about substantial reductions in the costs of childbirth, therefore, depends more on producing cheaper baby clothes, prams and other equipment than on lowering further the cost of medical care.