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What does it take to have a strong and independent profession of midwifery? Lessons from the Netherlands

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ABSTRACT

In the 1970s, advocates of demedicalising pregnancy and birth 'discovered' Dutch maternity care. The Netherlands presented an attractive model because its maternity care system was characterised by a strong and independent profession of midwifery, close co-operation between obstetricians and midwives, a very high rate of births at home, little use of caesarean section, and morbidity and mortality statistics that were among the best in the developed world. Over the course of the following 40 years much has changed in the Netherlands. Although the home birth rate remains quite high when compared to other modern countries, it is half of what it was in the 1970s. Midwifery is still an independent medical profession, but a move toward 'integrated care' threatens to bring midwives into hospitals under the direction of medical specialists, more women are interested in medical pain relief, and there is a growing concern that current, albeit slight, increases in rates of intervention in physiological births foreshadow the end of the unique approach to birth in the Netherlands. The story of Dutch maternity care thus offers an ideal opportunity to examine the social, organisational, and cultural factors that work to support, and to diminish, the independent practice of midwifery in high-resource countries. We may wish to believe that providing ample and convincing evidence of the value of midwifery care will be enough to promote more and better use of midwifery, but the lessons from the Netherlands make clear that an array of social forces play a critical role determining the place of midwives in the health care system and how the care they provide is deployed.

Introduction: The Netherlands as a model

The Netherlands has long been regarded as a model of a well-organised maternity care system where the autonomy of midwives promotes normal, optimal birth, free from the unneeded interventions found in many other high-resource countries. Dutch maternity care is based on a careful delineation of 'physiological' and 'pathological' pregnancy and birth, with a rational and safe division of labour among primary ('first line') and specialist ('second line') care. Midwifery in the Netherlands is legally defined as a medical profession, making Dutch midwives independent practitioners. Because they are not nurses and because they are licensed as medical practitioners – with expertise in physiological pregnancy and birth – they remain free from supervision by clinicians. This independence gives greater freedom to birthing women: whereas women in most other high-resource countries must struggle to organise a birth at home, women in the Netherlands have an easy choice of where their babies will enter the world: home, birth centre, polyclinic,[2] or hospital.

Like midwives in many other European countries (and unlike the United States and Canada, where specialists manage nearly all births), midwives in the Netherlands are responsible for the care of women with a healthy pregnancy who are expecting a physiological birth.[3] Indeed, more than 80 per cent of all pregnant women

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[2] Polyclinic births are best described as midwife-led hospital births – polyclinics are located in hospitals and births are completed there without supervision from gynaecologists.

[3] Like others we have debated the best term to describe births without interventions: normal, optimal, healthy, physiological? Each word has its

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in the Netherlands begin care with a midwife (PRN, 2013). Unlike other European countries, autonomous Dutch midwives provide care during labour and birth independently. At home, in birth centres, or in a polyclinic setting, the midwife is the professional in charge. The rate of births at home is a distinguishing feature of the autonomy of Dutch midwives; although the rate has declined recently, home births account for nearly 20 per cent of all births in the Netherlands with an additional 11 per cent of births attended by midwives in polyclinics (CBS, 2012; PRN, 2013). By comparison, home birth rates in other developed nations are low, if not miniscule.

It is this aspect of Dutch maternity care – autonomous midwives delivering babies in non-medical settings – that inspires those who would like to see a greater role for midwives in maternity care. For many outside the Netherlands, the model of midwifery in the Netherlands is seen as a way to reverse or slow the medicalisation of birth, a process where 'the overuse of drugs and technologies such as labour induction, oxytocin augmentation, electronic fetal monitoring, episiotomy, and caesarean section' leads to 'unnecessary iatrogenic physical, social and emotional damage' (Davis-Floyd et al., 2009). Activists who wish to change the way birth is accomplished in their native lands look to, and regularly visit, the Netherlands for instruction on how to make home birth a safe and easily accessed option for women.

There is much to learn from maternity care in the Netherlands. The Dutch Obstetric Indication List (the VIL)[4] – a method of aligning provider competencies with the health status of pregnant women ('risk selection'), developed and revised over decades with input from midwives and gynaecologists[5] (KNOV, 2003) – coupled with training programs that emphasise co-operation between first and second line maternity care providers (De Vries et al., 2009) form the foundation of a system of care that is organised to help women in modern nations avoid the unneeded interventions that occur when healthy women birth in hospitals or birthing centres (under the care of clinicians or midwives, see Birthplace in England Collaborative Group (2011) and Janssen et al. (2009)). The continued use of birth at home in the Netherlands suggests to women elsewhere in the world that birthing without medical interventions is not only possible, but safe, creating a revival of independently practicing midwives. Witness to this revival is found in the small but significant increase in the rates of home births in other countries. In the past several years New Zealand (New Zealand Ministry of Health, 2012), the United States (MacDorman and Declercq, 2011), Canada (Murray-Davis et al., 2012), Australia (AIHW, 2012) and the UK (Birthchoice) all have seen a rise in the number of births at home.

But things are changing in the Netherlands. While the Dutch system still stands out as one that protects and promotes physiological birth – rates of induction, epidural use, and caesarean section are among the lowest in the industrialised world (Christiaens et al., 2013; PRN, 2013) – changes over the past decade (including a decline in home births and a slight upward trend in interventions in birth) pose challenges for the autonomy of midwives and the ability of women to easily choose birth at home.

These changes give us the opportunity to untangle the complex and interconnected factors that determine the place of midwifery in a health care system. Analysis of maternity care in the Netherlands reveals how social and cultural factors shape the way the services of midwives are used and serves as an important reminder that the use of evidence about the benefits of midwifery care – no matter how persuasive – will not be enough to promote greater use of the services of midwives.

Half empty or half full? Changes in maternity care in the Netherlands

Those who fear for the future of the Dutch model of birth base their fear on the home birth rate in the Netherlands. In spite of the fact that midwives are in charge of all polyclinic births, the number of births at *home* is seen as a critical measure of the autonomy of Dutch midwives and the 'health' of Dutch maternity care. Using this criterion, the cup appears half empty: since the 1990s there has been a steady decrease in the number of women who complete birth at home (Table 1).

The decreased use of home birth has not been compensated for by a shift of births to other primary care settings: in 2000, 34.9 per cent of births occurred at home, in birth centres and the polyclinic, and in 2010 that number dropped to 28.8 (PRN, 2011b, 2013). Some of this decline is the result of fewer general practitioners offering care at birth, but the numbers underscore a movement from settings that protect the autonomy of the midwife – homes and polyclinics – to those where midwives are not in charge.

The increase in hospital births in the Netherlands is being driven by a higher rate of referrals from midwife to specialist care. Whereas the number of women who begin care with a midwife remains quite high – 83.9 per cent in 2010 – the number of women who birth under the sole care of a midwife has declined steadily (Table 2).

How are we to interpret the increasing rate of referral? Are women less healthy? Have midwives, obstetricians, and women become more cautious? In their analysis of the indications for referral Amelink-Verburg et al. (2009) discovered that between

Table 1
Place of birth in the Netherlands 1998–2010 (as a per cent of all births).
Source: CBS (2012). On the basis of a national survey; 95 per cent confidence level for all years is ±3.3 per cent. See Appendix A for an explanation of the varied data sources related to Dutch maternity care.

Year	Home	Hospital
1994/1996	34.1	65.3
1998/2000	34.1	65.8
2001/2003	31.9	67.9
2004/2006	31.6	67.8
2005/2007	29.4	70.2
2006/2008	28.4	71.4
2007/2009	23.9	75.6
2008/2010	23.4	75.3

Table 2
Referrals from primary care to specialist care 2000, 2005, 2008–2010.
Source: PRN (2011a, 2011b, 2013).

Year	Number beginning in primary care (Per cent of all pregnancies)	Number where child was *born* in primary care	Per cent referred antepartum +intrapartum	Per cent not referred antepartum +intrapartum
2000	157082 (82.1)	69261	55.9	44.1
2005	147292 (82.9)	62008	57.9	42.1
2008	149613 (84.2)	57819	61.4	38.6
2009	152177 (84.3)	57302	62.3	37.7
2010	147919 (83.9)	50534	65.8	34.2

(*footnote continued*)
drawbacks, but we settled on physiological, in part because it is the term the Dutch have used routinely.

[4] In Dutch, the *Verloskundige Indicatielijst* (VIL).

[5] We use the Dutch term, gynaecologist, to refer to the medical specialist that provides care for pathological pregnancies and births. In the Netherlands, the term obstetrician is seldom used, a fact that may be related to a clear division of labour between these specialists and midwives.