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Dutch Midwifery

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Simone Valk and Rebekka Visser explain why Dutch midwifery is threatened by market forces

As many of you may know, the Netherlands, once the Mecca of independent midwifery and homebirth, are not doing particularly well in the perinatal statistics ranking.[1]

And of course the reflex reaction of many is: blame the homebirth and the independent midwife. This is despite good evidence that homebirth is safe,[2] that midwife led care is the best and the cheapest option, that most perinatal deaths occur with extreme prematurity (of before 28 weeks) and congenital defects, and that differences in outcomes between various countries can also be explained because of different means of record keeping.

We will give a brief sketch of the system.

Healthy pregnant women, that is the majority of women, will see a midwife during pregnancy. If no complications arise the midwife will help her during labour and birth and attend her during the first week with home visits while the *kraamverzorgende* takes care of mother and baby. *Kraamverzorgenden* are post partum doulas who assist the midwife during a homebirth, and who come to the house of the new parents during the first 8-10 days. They help the mother to cope with looking after her newborn and with breastfeeding and do light household chores.[3] The Kraamzorg has been around for a long time: certainly before World War Two.

If a complication of any kind occurs during pregnancy or birth the midwife is supposed to refer the woman to a consultant and ask for his or her expert opinion. After a consultation, he or she will give their advice to the midwife and mother and they, between them, can decide on the best course of action. In practice the consultant tells the midwife what should be done. The midwife gives in mostly because the mother places her trust in the doctor. Midwives no longer have time to build relationships with mothers – which we will go on to explain below.

Reasons for referral to a consultant are written down in the VIL (Verloskundige Indicatie Lijst): the obstetrical indication list that some regard as set in stone. We are now on the fourth version of this list and the number ofindications have tripled since the list was first published in the 1990s. In recent years the pressure on midwives to refer according to the VIL has increased, due to fear of litigation. Midwives have been reported for not obeying the VIL.

In the early years of the 21st century there was a real shortage of midwives. Too many left the field and

there were not enough new midwives to replace them. Work then was extremely demanding. Midwives were burning out fast and furiously. Together, we stuck our 'fingers in the dyke'. This led to solo midwives starting to work together in shifts, part of the woman's care during labour was left to the kraamverzorgenden, and women were encouraged not to have a homebirth, but a birth centre or hospital-based birth, so that one midwife could attend more than one woman at the same time.

So personal support seriously suffered. Many a midwife has heaved a sigh of relief in the middle of the night if a complication such as meconium showed as it meant a referral and therefore a few hours of much needed sleep. Midwives who refer a woman, generally leave her to the hospital team. The workload of the average midwife in those days was 150. But please bear in mind that this did not mean 150 women but 150 financial units. Midwives are paid for parts of care. Childbirth is divided up into three parts: pregnancy, labour and birth, and postnatal care. Pregnancy itself is also divided into three parts, 0-14 weeks, 15-29 weeks and 29 weeks to birth. So if a midwife attends a woman only postnatally she gets paid for that part of care. Four women for postnatal care, make up the same amount of money as caring for one woman throughout pregnancy, birth and postnatally. In 2010 this was reduced from 150 to 105 units, which still means 130 women. This is an insane workload.

Local relationships between midwives and obstetricians vary vastly. In Rotterdam for instance, there are five hospitals with maternity units, but in smaller towns, there is often just one hospital. Depending on location, the dynamics between midwives and obstetricians are totally different.

In some hospitals, obstetricians are employed while in others, doctors who are in private practice, use and pay for hospital facilities.

Hospital budgets and allocated numbers of births within each local budget have become very complicated with changes in the national health system; for instance, if the hospital has a set allocation of 2,000 births per annum, birth number 2001 actually costs the hospital money. Hospitals want women to give birth there, but they do not want to exceed their budget.

In any given geographical area, midwives and doctors are meant to work together through what is called the VSV (a body that discusses clinical care and makes decisions concerning clinical rules and guidelines). Coping strategies have led to midwifery practices, varying from two to 10 midwives. Women have little choice, because most practices refuse clients outside their postal code area. For women it is very hard, if not impossible to form a relationship with 'her' midwife if she has to see all 10 members of the team during pregnancy.

In the meantime hospitals discovered that midwives are better than untrained junior doctors and many midwives liked the idea of working in a hospital with regular hours and never alone in dire circumstances.

Reorganisation of the maternity services under new regulations about hospital structures and financing

The entire system of financing of health care services was changed by national legislation in 2006.

In 2006 the Netherlands saw a large change in health insurance. Up until then, most people had either private insurance or *ziekenfonds*, a form of state-funded health care. Under a certain income a person was *ziekenfonds* insured and above it they were required to buy their own private health insurance. In 2006 this all changed to one kind of insurance. Everybody is obliged to have a basic health insurance and health insurance companies which are private providers cannot refuse to provide basic health care insurance. Children under 18 are insured for free. The four insurance companies in the Netherlands were given the power to reform healthcare into a financially profit driven healthcare market. They were supposed to buy the best healthcare for the lowest prices for their clients but in practice it is the lowest price which determines their choice. Care during pregnancy, birth and the postnatal period and*kraamzorg* (postnatal doulas) are still covered by the basic health insurance.

These changes and accompanying administrative changes, including a shift to this mixed public-private system with private health insurance companies playing a major role, have had a major impact on health care services and their effect has been highly variable in respect of maternity services.

Midwives have their own contracts with insurance companies. As I explained midwives are paid for units of the care. So, for example, if a woman is referred to an obstetrician during pregnancy, the midwife gets paid for care from the beginning of the woman's pregnancy until 30 weeks or later, depending on the referral date and for postnatal care, from when the woman goes home after the birth. When a woman is referred during birth the midwife gets paid the whole amount, so there is no financial incentive for keeping a woman in her care who really needs a consultant. And the consultant who takes over the birth also gets paid the full amount.

Women who want a hospital birth without a good medical reason have to pay for it themselves. If she decides to have an epidural during labour this is seen as a medical reason, so both midwife and consultant get paid and the woman herself does not have to pay.

180,000 children are born each year but insurance companies pay for almost 280,000. This is largely because of all the referrals during labour and birth where both parties get the full amount of money. It is not exactly rocket science to conclude that this can be done more cheaply. And with the perinatal statistics still under debate, the solution seems easy: stop homebirths and bring midwives to heel.

Over the last decade hospitals have merged so that there are now fewer hospitals. Generally local relations between midwives and consultants are reasonably good, largely because both are independent professionals who complement and respect each other. There is a lot of personal appreciation. Most work on a basis of trust and respect. In recent years however, it has become clear that midwives with comparable populations of women have very different referral rates, varying between 35% and 70%. The reason for this remains unknown. It would seem prudent to research this phenomenon thoroughly before implementing changes.

However, the new modes of health financing are complex and under these new modes the idea is for a VSV to get a lump sum of money for all the births in their area. Midwives and obstetricians must divide this allocation amongst themselves, while the hospital is also a stakeholder in its own right. Caught in the middle of this process of change, no one knows yet what it will look like over the next number of years. One of us has a practice which covers three hospitals, but as midwives we only participate in one VSV because the rules state that midwives and obstetricians can only participate in one VSV.

And of course the party that manages the money will have the power. Most consultants work in a hospital, but not all are employed by the hospital. The hospital lobby is very forceful. While no decision has been reached as yet, there is ample reason to believe that it won't be midwives managing the money. It may mean that midwives will no longer be autonomous professionals but will have to work under the supervision of consultants. It may mean that homebirth will no longer be possible or if a woman insists, that she will have to pay for it because she wants a midwife all for herself.

Of course this whole change to 'Shared Care', is framed as concerning safety. In all other areas of health care the GP is considered to be a gatekeeper. The GP is supposed to deal with most matters and only to refer to an expensive hospital-based specialist if there is no other solution. But in pregnancy the recommendation is now for ALL healthy pregnant women to be seen by a consultant at least once. And of course for midwives to share files.

Better? No evidence for that so far. Cheaper? Who knows. Will the results be improved by constantly givinghealthy women a message that we don't think she can carry her child to term and give birth like her mother, her grandmothers and all women since Genesis? Do we as a society have the right to take away from a woman choices regarding her bodily integrity?

Will we in ten years time look back and say: gosh, look what we had and look what we have now? More interventions, more caesarean sections and more unhappy women than ever and the costs of birth soaring.

Midwives at the moment are uniting and trying to influence these plans. But we see that it is very difficult for them to keep track of everything that politicians say and do. Vague language and smoke screens are difficult to navigate and not everyone is filled with a sense of urgency or is convinced that these plans are really harmful and will lead to the end of midwifery as we know it. In the last two years, an active woman's organisation, *Geboor tebeweging*, has developed, which makes itself very visible and audible. It too fights for independent midwifery and for choice for a woman to birth where and with whom she wants.

Hospitals are merging: centralising care is the idea, and women will have to travel a larger distance to reach the hospital. In one area, where a local hospital closed, home births were 'forbidden' (in that midwives were made to understand that they were taking risks with the lives of mothers and babies if they still supported homebirth). The distance to the hospital was considered too dangerous in case of an emergency. However the midwives in this area have reported an increase in homebirths recently with no

adverse effects.

We see more women these days who don't want to give birth in a hospital despite, a clear medical reason. Some mothers have been reported to social services for taking 'risks' with their babies. Midwives attending these women were reported too and have been under investigation by the Health Care Inspector. The personal impact for the midwife and the damage to her professional reputation is great and not every one can stand this strain. In general it's clear that Dutch midwives AND women feel great concern about the recent developments. And it is also clear that they will need firm political and public support in this increasingly profit driven system. Healthcare should not be a market, and access to good quality care for all should be a shared responsibility of society at large.

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3. See wikipedia.org/wiki/Kraamzorg for more information