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## The organisation of midwifery care in the Netherlands

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**Chapter 1**

**Introduction**

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# Introduction

"*Restrict the freedom of midwives*" headlined the national newspaper Trouw on the first of July 2016 "*....in order to decrease perinatal mortality*" was added in other social media. The chairman of College Perinatale Zorg (CPZ) stated a few months earlier (14 April 2016): "*In the past, things went wrong because the primary care midwife was not able to carry out risk selection appropriately, with all its consequences. Therefore the perinatal mortality in the Netherlands is so high*". A few years earlier this negative media attention for the midwifery profession began with a perceived poor ranking in the European perinatal mortality statistics. "*Don't try this at home*", was the heading on the front page of the national newspaper NRC-next on the third of November 2010 regarding home births and NRC-Handelsblad stated: "*Births under the supervision of a midwife (...) are a lot riskier than previously thought*". Dutch maternity care is in motion. At present, there is a dialogue on the reorganization of the maternity care system in the Netherlands. This dialogue centres on the need to integrate care more effectively between the various maternity care providers. This may lead to major changes in the organisation of midwifery care. While the contemporary echelon system recognises roles for primary, secondary and tertiary care, consensus seems to be building for a more integrated maternity care system.

This thesis focuses on the organisation of midwifery care in the Netherlands and on views regarding changes to the organisation of midwifery care. Furthermore, this thesis seeks and identifies components of care organisation, which are likely to be conditional for successful collaborative midwifery practice in the future. We need good evidence on where the midwifery field is at, before we change it. It is important, not only for the Netherlands, but also for other countries where midwifery-led care and home birth are increasingly being encouraged and where maternity care is being reorganized. Dutch maternity care provides a unique research arena and this thesis describes the often invisible (and sometimes disparaged) work of primary care midwives. This thesis is making a contribution in terms of informing and updating information about how primary care midwives are practicing and their impressions about the future.

What can be said about the way the maternity care is organised from midwives' perspectives? The first part of this thesis is human resource management related. In the last decade there were quite dramatic changes and pressures within the system on primary care midwives and midwifery care. In that context, little is known about the job satisfaction of the primary care midwives or their intention to maintain primary care practices. We do not know how many

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primary care midwives are considering leaving their current job, nor factors associated with a desire to leave primary care. The second part of this thesis gains insight in the nature of the work provided by the primary care midwives within the contemporary echelon system, their workload and their collaboration with other maternity care providers. In the whole picture of reorganization of maternity care, it is important to know how midwives organise their jobs and how they relate to other maternity care providers. In the light of the current drive to further/better integration of maternity care it is essential to understand the way in which professionals have shaped the interdisciplinary collaboration to date. Understanding the perspectives of the current group of practicing primary care midwives regarding their work situation can help further midwifery policy and education. In addition to the point of view of the primary care midwives regarding the organisation of care, the perspective of student midwives, with experiences in primary, secondary and tertiary maternity care are described in the third part of this thesis, in order to understand new professionals' perspectives on potential changes and priorities of midwives within that change.

### *Paradox of the Dutch maternity care system*

The Dutch maternity care model is known worldwide for its midwifery (humanistic/holistic) model of care (Davis-Floyd, et al. 2009b), with the autonomous position of primary care midwives (Wiegers, 2007), low rates of intervention and high rates of home births (Davis-Floyd, et al, 2009a). Maternity care is all care related to pregnancy and childbirth; midwifery care is that part of maternity care that is provided by midwives and/or from a humanistic viewpoint. The Netherlands has a remarkable midwifery history, which has led to a unique maternity care model. Special features of its maternity care are the social and financial structure of Dutch maternity care, the application of a risk selection system to differentiate between primary and secondary care, the independent position of the midwifery profession, the availability of maternity care assistants, the special position and high level of training of Dutch midwives that qualify them to practice independently, and the philosophy that pregnancy and childbirth are fundamentally normal events that do not require medical interventions unless there is a clear need for them (de Vries, 2005; de Vries, et al., 2009; Schultz, 2014; Wiegers, et al., 1998).

### *Current organisation of midwifery care in the Netherlands*

At this moment, like all health care, the maternity care in the Netherlands is organised in echelons, with a strict role division between primary, secondary and tertiary care (Rowland, et al., 2012). In primary care, midwives - and to a small extent general practitioners – provide care to healthy women with uncomplicated pregnancies throughout their pregnancy, labour and six-weeks post partum.

These primary care providers have a gate-keeping role (Bais & Pel, 2007). In case of complications, or if the woman requests a form of pain relief that can only be given in secondary care, the woman is referred to obstetricians -also known as gynaecologists or Obstetrics and Gynaecology specialists- and clinical midwives in a hospital (secondary care), or an academic referral centre (tertiary care). Since 1987 (Meijer, 1997), the Obstetrics Indications List (College van Verzekeringen, 2003) carefully distinguishes between 'physiological' and 'pathological' pregnancies and births, and women in the first category are reimbursed only for care provided by primary care providers.

Primary care midwives are medical professionals and play a key role as providers of maternity care in the Netherlands. In 2013, 85.4% of all pregnant women in the Netherlands received care in early pregnancy from a primary care midwife, 50.6% started labour and 28.4% of all births (n=167.159) were supervised by a primary care midwife at home or in a hospital or birth centre (The Netherlands Perinatal Registry, 2014).

In 2012, 2,692 midwives are practicing in the Netherlands (Hingstman, et al., 2013). However, a growing proportion (27% in 2011, compared to 16% in 2001) of midwives are employed by hospitals as clinical midwives and work under supervision of obstetricians, where they care for women who have been referred to secondary care (Hingstman, et al, 2011). Primary care midwives work in private practice as self-employed practitioners, alone or in partnership with one or more other midwives, or as employee in someone else's practice or as locum, filling in vacancies in midwifery practices on a temporary basis. Table 1 shows that up to 1980, less than 10% of primary care midwives worked in group practices; most worked single-handedly and were on call 24/7, offering a high level of continuity of care. Just three decades later, the majority of Dutch primary care midwives work in group practices of three or more midwives (Hingstman, et al. 2013; Schultz, 2014). The move to group practice is a logical strategy for primary care midwives who want to create a more balanced life, but it subtly alters the relationship between midwives and mothers (de Vries, 2009). The number of midwifery practices has increased from 452 in 2004 to 519 in 2011 (Kenens & Hingstman, 2004; Hingstman & Kenens, 2011). The average practice size has remained fairly stable over the years and was 3.1 midwives per practice in 2011 (Hingstman & Kenens, 2011).

**Table 1. Distribution of primary care midwives working in different type of practices, 1980 – 2012 (Hingstman, et al. 2013)**

	Solo		Duo		Group		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
<b>1980</b>	391	67.6	136	23.5	51	8.8	578	100
<b>1985</b>	322	46.8	269	39.1	97	14.1	688	100
<b>1990</b>	235	27.6	326	38.3	291	34.2	852	100
<b>1995</b>	135	13.2	316	30.8	575	56.0	1,026	100
<b>2000</b>	88	7.2	243	19.9	889	72.9	1,220	100
<b>2005</b>	63	4.3	189	12.8	1,222	82.9	1,474	100
<b>2010</b>	80	4.9	221	13.6	1,324	81.5	1,625	100
<b>2012</b>	84	5.2	225	14.0	1,298	80.8	1,607	100

Up to 1994 primary care midwives were expected to have a standard caseload (in Dutch: normpraktijk) of 165 per year, which is the number of 'care units' a full-time working midwife will need to see, to reach the 'normatieve' annual income. A 'care unit' is the equivalent of one client receiving care throughout pregnancy, childbirth and the postpartum period (de Vries, 2005; Wiegiers, 2007). As a result of several protests by midwives this yearly 'standard caseload' was reduced to 150 'care units per year in 1994 (de Vries, 2005), to 120 'care units' in 2001, and to 105 per year in 2010 (KNOV, 2015). Comparison at the level of 'caseload' (105 'care units' in the Netherlands, 40-45 clients in Australia and 25-28 clients in the UK (Paterson, et al., 2010; RCoA, RCM, RCOG, RCPCH, 2007)) shows that the differences between countries are large (or that there are differences in the definition of what a 'standard caseload' means).

### *Pressure for change*

Unique as it may be, the Dutch maternity system is characterised by an edgy paradox. On the one hand, other countries, such as Canada, the United Kingdom and New Zealand took the Netherlands as an example for changing their

maternity care systems (de Vries, et al, 2009; Malott, et al., 2009). In these countries too, midwives increasingly work autonomously and the homebirth rate is rising. On the other hand, the quality of care of the 'Dutch' way of birth has been increasingly brought into question. Organisational, relational and coordination factors have been identified as disrupting the smooth functioning of the maternity care, such as a lack of shared maternity notes system, misaligned financial incentives, different perspectives on antenatal health and suboptimal inter-professional communication (Schölmerich, et al, 2014). Recent research indicated that clarity on each profession's role and responsibilities within the collaboration seemed to be lacking and that many professionals did not perceive themselves as being an integral part of a team (van der Lee, 2014). Also, there has been a considerable rise in non-urgent referrals to obstetrician-led care from primary midwife-led care during labour (Perdok, et al. 2014; Offerhaus, et al, 2013), all of which is challenging the sustainability of the current strict role division between primary and secondary maternity care in the Netherlands (Offerhaus, et al, 2013; Perdok, et al, 2014; Posthumus et al, 2013; Schölmerich, et al. 2013). Furthermore, following the relatively high perinatal mortality in the Netherlands (Peristat II, 2008) the advisory report 'A Good Start' (Stuurgroep, 2009) was released. The core of the report was the need to improve the quality of maternity and perinatal care by closer cooperation and better communication between all maternity care professionals. To achieve this, a so-called 'integrated care' approach (CPZ, 2014) was introduced, including a proposal (Schippers, 2014) for a fusion of the maternity care professional societies or organisations (van der Lee, 2014). This approach was supported by health insurance companies strongly advising obstetricians and midwives to collaborate in a professional as well as a financial partnership (van der Lee, 2014). It could be a major change in the history of midwifery care in the Netherlands, going from the echelon system to a more integrated maternity care system (de Vries, et al., 2013; de Vries, 2014; Roman & van den Wijngaart, 2011).

## The general aim of this thesis

This thesis focuses on the organisation of midwifery care in the Netherlands and on views regarding changes to the organisation. Furthermore, this thesis seeks and identifies components of care organisation, which are likely to be conditional for successful collaborative midwifery practice in the future.

The following research questions were addressed in this thesis, from the human resource related and work content related perspective of primary care midwives:

1. How do primary care midwives feel about their work and identify factors associated with primary care midwives' job satisfaction (Chapter 2)?

2. Is there an association between intentions of primary care midwives in the Netherlands to leave their job and factors associated with the likelihood of making this choice, such as their work-related and personal characteristics and attitudes towards work?
  - a. What are the career plans of primary care midwives in five years' time regarding their near future and ideal work situation? (Chapter 3)
  - b. What are the differences in career plans between midwives who have an intention to leave their current job and midwives who have no intention to leave? (Chapter 3) What is the relationship between the primary care midwives' intention to leave their current job and their work-related and personal characteristics, and attitudes towards their work? (Chapter 3)
3. What is the content of the work and the workload of primary care midwives in the Netherlands?
  - a. What is the workload of a primary care midwife in the Netherlands, in terms of duration: the number of hours a primary care midwife is working per week, and in terms of caseload: the number of clients a primary care midwife sees in a year? (Chapter 4)
  - b. What is the content of the work of a primary care midwife in the Netherlands, in terms of: time spent on client and non-client related activities, and in terms of time spent on different aspects of client care? (Chapter 4)
4. Are there differences in how primary care midwives experience satisfaction when collaborating with other maternity care providers? What is the relationship between the primary care midwives' 'satisfaction with collaboration' and midwives' work-related and personal characteristics, attitudes towards their work and collaboration characteristics? (Chapter 5)

And from the perspective of future midwives with experiences in secondary and tertiary maternity care as well as in primary care:

5. What are the perceptions of final year midwifery students in Amsterdam (VAA) and Groningen (VAG) on possible future forms of cooperation in the maternity care, including integrated care? (Chapter 6).

## Methods

This thesis forms part of the descriptive DELIVER study (Dutch acronym for 'data primary care delivery': Data EersteLIJns VERloskunde) conducted by the Department of Midwifery Science of VU University Medical Centre, Amsterdam. The DELIVER study was a multicenter study in the Netherlands which was the first large-scale study evaluating the quality and organisation of primary midwifery care (Manniën, et al., 2012). Between September 2009 and April 2011, DELIVER data were collected from midwives and from clients and their partners in 20 midwifery practices across the Netherlands. The participating practices (20 of the 519 midwifery practices in the Netherlands) comprised 108 midwives and a caseload of 8,200 clients per year, with all regions of the Netherlands being represented. The 108 individual midwives were asked to complete a questionnaire, in order to gain insight into their tasks and attitude towards their job and their collaboration with other maternity care providers. Besides, midwives from the twenty participating DELIVER practices recorded work-related activities in a diary for one week, to assess workload. Another questionnaire was sent to all 519 Dutch midwifery practices, which reveals information regarding the organisation of midwifery practices and collaboration with other care providers.

Besides the DELIVER study, for this thesis in-depth interviews were held in 2014 with 18 final year students about the current and anticipated maternity care models.

## Content and outline

This thesis focuses on the organisation of midwifery care in the Netherlands and on views regarding changes to the organisation. Furthermore, this thesis seeks and identifies components of care organisation, which are likely to be conditional for successful collaborative midwifery practice in the future. The first part is human resources related and explores how much the primary care midwives like what they are doing and how they see a future for themselves within the profession. In chapter 2 three open-ended questions were analyzed to identify factors that are linked with primary care midwives' job satisfaction: "What are you very satisfied with, in your work as a midwife?", "What would you most like to change about your work as midwife?" and "What could be improved in your work?". In chapter 3 the association is assessed between intentions of primary care midwives in the Netherlands to leave their job and factors associated with the likelihood of making this choice, such as their work related and personal characteristics, and attitudes towards work. Furthermore the career plans of primary care midwives who have an intention to leave are compared with those

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midwives who do not have an intention to leave. The second part of this thesis investigates the work content of the primary care midwives. In chapter 4 the work and the workload of primary care midwives is described on the basis of time registers the midwives kept 24 hours a day, for a week and gives information about practice size. Chapter 5 provides insight into the professional working relations of primary care midwives in the Netherlands. In addition to the point of view of the primary care midwives regarding the organisation of care, in chapter 6 a qualitative study among student midwives is presented in which their views on the organisation of maternity care systems are described. Finally, in chapter 7 the main findings of the studies are summarized and their implications for practice and future research are discussed.

### Overview

Question	Chapter	Data source	Study sample	Methods
<b>Q1</b>	2	DELIVER Individual questionnaire	99 primary care midwives	Observational cohort Descriptive analysis Content-analysis
<b>Q2</b>	3	DELIVER Individual questionnaire	98 primary care midwives	Observational cohort Descriptive analysis Logistic regression
<b>Q3</b>	4	DELIVER Time-registration Practice questionnaire	99 primary care midwives & 319 midwifery practices	Observational cohort Descriptive analysis
<b>Q4</b>	5	DELIVER Individual questionnaire	99 primary care midwives	Observational cohort Descriptive analysis Friedman's ANOVA
<b>Q5</b>	6	In-depth interviews	18 final year student midwives	Constant comparison Qualitative analysis

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