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Midwifery in the Netherlands: Vestige or Vanguard?[1]

Raymond DeVries

The midwifery system of the Netherlands, where nearly one-third of births occur at home, is widely admired by birth activists. Why has the Netherlands maintained this way of birthing babies when all other European countries have shifted to hospital-based maternity care? In this article, I examine the societal forces – both structural and cultural – that allowed the Dutch to hold on to a way of delivering maternity services that other modernizing nations discarded earlier in the first half of the 20th century.

Key Words: midwifery, Netherlands, health systems, culture

On June 2, 1994, an extraordinary meeting took place in the Dutch town of Ede. The Netherlands Organization of Midwives (NOV),[2] with the support of the Ministry of Welfare, Health and Culture (WVC),[3] sponsored a one-day conference to inaugurate a public campaign to promote birth at home. Under the title, *Een Goede Keuze Bevalt Beter* (A Good Choice Means a Better Birth),[4] the purpose of the symposium was to consider ways to halt what many believed to be a worrisome decrease in the number of Dutch women choosing to have their babies at home. Included on the program were representatives of physicians' organizations (both general practitioners

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and gynecologists),[5] government officials, researchers, policy makers, and representatives of consumer organizations.

Those who attended the symposium heard reports of government-financed research on midwives' attitudes toward place of birth (midwives find home birth both more satisfying and more intense than hospital birth) and on the safety of home birth for properly screened women (birth at home is at least as safe as hospital birth for women having their first child; for women who have already had one child, home birth brings better results). They heard Mevrouw Netelenbos, chairperson of the Dutch parliament's *Commissee voor de Volksgezondheid* (Committee for Health), proclaim the government's respect for the autonomy of midwives and its willingness to support them: "The midwife can do much on her own, but she must be protected. The government cannot stand at a distance" (Amelink and van Leent 1994). And they heard the executive director of the NOV, Mevrouw Zwart, reflect on the *weeën* of the campaign. *Weeën* is the Dutch word for the contractions of labor, but it can also be translated as the "W's," as in *wie* (who), *wat* (what), *waar* (where), *wanneer* (when), and *waarom* (why). She described the audience targeted by the campaign (pregnant women, their partners and other influential relatives, as well as midwives and other caregivers), the means of conducting the campaign (brochures, press releases, a nationwide telephone information line, and visits to groups of midwives, nurses, and physicians), and the *waarom* of the campaign – the preservation of the possibility of choice in the place of birth, giving special emphasis to birth at home.[6]

To the Dutch this meeting did not seem unusual. It is not uncommon for the government and professional associations to join together in campaigns in the interest of public health. But to us *buitenlanders* (foreigners), the conference is nothing short of incredible. Public promotion of home birth? With the full support of the government? In the United States, home birth is thought to belong to the Dark Ages of medicine; those choosing home birth in the United States have been identified as members of the "lunatic fringe." Physicians (including specialists!) joining together with midwives to promote home birth? Midwives in the United States have become accustomed to physician resistance to their practicing in *hospitals*: to have a physician publicly support midwife-assisted birth at *home* is nearly unthinkable. But perhaps most remarkable to an outside observer is that the Dutch felt the *need* to promote home birth: in the mid-to-late 1990s about one-third of all births in the

Netherlands took place at home: no other nation with a technologically advanced medical system had a home birth rate above 3 percent during those years.

The Dutch obstetric system has almost legendary status among childbirth activists who see the system as a model, a vanguard for change. But not everyone shares this view. There are others – both outside and inside the Netherlands – who are convinced that the Dutch way of birth is nothing more than a vestige, a remnant from an earlier period in history. Vanguard or vestige? Is midwifery in the Netherlands just another quaint feature of the lowlands, akin to wooden shoes, destined to disappear from everyday practice? Or have Dutch midwives discovered a way to survive that bodes well for the future of midwifery elsewhere? In order to answer these questions we must look closely at the societal forces – both structural and cultural – that allowed the Dutch to hold on to a way of delivering maternity care that other modernizing nations discarded in the first half of the 20th century. But first I must briefly describe the obstetric system of the Netherlands and explain how it works.[7]

My description and analysis of Dutch midwifery is based on 16 months of research conducted between 1994 and 1995. During my time in the field I interviewed midwives, clients, gynecologists, midwife educators, government officials, policy makers, researchers, staff of the association of health insurers, staff of the professional associations of midwives, general practitioners, and gynecologists. I visited several midwife practices and all three schools of midwifery. I read all major government reports on midwifery published since 1940 and countless articles in the professional journals of Dutch midwives, general practitioners, and specialists. I also read popular literature related to birth and midwifery, including articles in newspapers, magazines, and "how-to" books for new mothers and fathers. Since leaving the field in 1995, I have been back to the Netherlands several times, both virtually and physically, updating my data and following developments in health care and midwifery.

THE ORGANIZATION OF DUTCH MATERNITY CARE

It is somewhat arbitrary to distinguish between the features that describe Dutch maternity care and the features that explain its existence. In the next few pages I describe the distinctive structural features of obstetrics and midwifery in the Netherlands.[8]

You will undoubtedly notice that several of these features could be used to explain the continued existence of the Dutch system; however, in this section my intent is simply to provide a picture of Dutch maternity care. In the next part of the article I make an effort to explain why the Dutch conduct maternity care in this fashion, revisiting some of these structural elements more analytically.

Unlike their sisters in other Western countries, pregnant women in the Netherlands can freely and easily choose to have their babies either at home or in a hospital. Writing for a Dutch audience, Hiddinga (1998:189) declares: "the possibility of a safe home birth is celebrated as great freedom of choice for Dutch women." Women's choices in birth care are made possible by a highly organized system that includes:

- Well-educated midwives, general practitioners, and specialists who – thanks to guidelines developed by government and insurance companies – know how to work with each other. There are clear boundaries between the "first line" (midwives and general practitioners) and the "second line" (specialists), and these boundaries are generally respected.
- "Polyclinic" settings in hospitals organized to provide low-technology, high-touch birth.
- A system for postpartum care in the home, complete with well trained *kraamverzorgsters* (postpartum caregivers).
- A system for well-child visits.

When a woman suspects she will be "getting"[9] a baby she will either do a self-test with an over-the-counter pregnancy test kit or make an appointment with her general practitioner (*huisarts*, pl. *huisartsen*) for a pregnancy test. Those who choose to do a home test will inform their *huisarts* if the results are positive. The *huisarts* is the hub of the health care system of the Netherlands: nearly everyone in the country is registered with a local *huisarts*, who serves as a family doctor and a "gatekeeper" to other medical services.[10] Only in the most exceptional cases would a Dutch woman who believes she is pregnant go directly to a gynecologist, and in nearly all of those cases she would do this on the advice of her *huisarts*.

Having confirmed her pregnancy and (perhaps) shared the news with relatives and friends, a Dutch woman can now contemplate how she will bring this child into the world. Will it be at home or in a hospital? What kind of practitioner will see to her prenatal care and attend the event? And what sort of care will be used after the birth?[11]

Dutch social policy directs women expecting a healthy[12] birth into the *eerstelijn* (first line), or primary care, system. In the *eerstelijn* either a midwife or a *huisarts* will provide all prenatal care and will *begeleiden* (accompany)[13] a woman at birth. Women under the care of the *eerstelijn* are free to choose to give birth at home or in the hospital. If they prefer a hospital birth, then they will have what is known as a *poliklinische bevalling* (polyclinic birth) under the supervision of their primary caregiver. The term "polyclinic" suggests a separate birthing center, but, in fact, there are only a few birth clinics in the Netherlands: a *poliklinische bevalling* is an uncomplicated short-stay (i.e., less than 24 hours) hospital birth. It should be noted that a woman's choice of caregiver in the *eerstelijn* is constrained by the *primaat* – a preference for midwifery care mandated by Dutch health policy. Because the government wishes to promote midwifery, midwives have been given the protection of the *primaat*. In other words, the rules of the insurance system insist that, in locations where midwives are practicing, women insured under the *Ziekenfonds* (the state organized "Sick Funds" that provide health care coverage for all those whose yearly incomes are below a specified level, about 65 percent of the population) *must* use their services. Thus the services of a *huisarts* can only be used in those places where no midwives are working.[14]

If complications arise during pregnancy or birth, the primary caregiver will refer a woman to the *tweedelijn* (second line), or specialist, care. After assessing the complication, the specialist – in this case a gynecologist – may send the woman back to the *eerstelijn* or keep her under his or her care in the *tweedelijn* for the duration of her prenatal care and for birth. All births supervised by a gynecologist take place in a hospital: some of these will require complete clinical care; others will take place in the polyclinic; and, if all goes well, mother and baby will return home within 24 hours.

Seventy percent of Dutch women begin their prenatal care in the *eerstelijn* (Weigers 1997:26). As a result of referrals made to the *tweedelijn* during the course of prenatal care and labor, midwives care for just under 50 percent of women at the time of birth, *huisartsen* an additional 10 percent, and gynecologists just over 40 percent. Of the women remaining in the care of the first line, about 60 percent give birth at home, resulting in a home birth rate of just over 30 percent.[15]

After a birth at home or in the polyclinic, a woman receives postpartum care at home from a specially trained caregiver known as a *kraamverzorgster. Kraamverzorgsters* do everything from household chores, to marketing, to cooking, to watching the condition of mother and baby, to offering instruction in baby care and feeding (see van Teijlingen 1990).

Seen from the point of view of other Western countries – where birth at home is very difficult, if not impossible, to arrange (see DeClercq et al. 2001) – Dutch women are in an enviable position. But the choices made available to women in the Netherlands come with a cost: in order to maintain a system that offers choice, certain individuals in that system must have their choices limited. Allow me to explain. At the outset I noted that the Dutch government supports birth at home. The government believes that unlimited choice for childbearing women could spell the end of midwife-assisted home birth, thus raising costs and harming the quality of birth care. For this reason Dutch women whose pregnancies proceed "normally" are not free to choose specialist care: these women must use primary care and can be attended either at home or in a polyclinic. This injunction is maintained via the insurance system (women with "normal" pregnancies and births will not be reimbursed for specialist care) and by professional custom (specialists will not attend normal births).

For women in countries where specialist care in pregnancy and at birth is the norm, this restriction would likely prove too much to bear. In the Netherlands there are occasional rumbles of discontent. Several years ago, for example, the Dutch magazine for women, *Opzij*, published an article that declared the denial of routine access to epidural anesthesia during labor to be paternalistic (Manschot 1993). However, by and large Dutch women, accustomed to the system, do not seem to mind their lack of direct access to the care of a gynecologist.

The Dutch way of organizing birth care produces the home birth rates and midwife assisted-birth rates for which the system is famous. Tables 1 and 2 present comparative data on place of birth and birth attendant for the Netherlands and for the United States, a country with a more medically and institutionally oriented approach to birth.[16] Along with high rates of home birth and midwife-assisted birth, the Dutch system yields lower rates of intervention. Figure 1 shows that the Netherlands has the lowest cesarean section rate among several European and North American countries.

TABLE 1. Distribution of Live Births By Place of Delivery and Attendant, 1940–1997, U. S. (%)

	Place of Delivery		Attendant		
Year	Hospital	Not in hospital*	Physician	Midwife	Other
1940	55.8	44.2	90.8	8.7	0.6
1945	78.8	21.1	93.5	6.1	0.3
1950	88.0	12.0	95.1	4.5	0.4
1955	94.4	5.6	96.9	2.9	0.3
1960	96.6	3.4	97.8	2.0	0.2
1965	97.4	2.6	98.3	1.5	0.3
1970	99.4	0.6	99.5	0.4	0.1
1975	99.1	0.9	98.8	0.9	0.3
1980	99.0	1.0	97.4	1.7	0.8
1985	99.0	1.0	96.7	2.7	0.6
1990	98.9	1.1	95.3	3.9	0.7
1991	98.9	1.1	94.8	4.4	0.8
1992	98.9	1.1	94.4	4.9	0.7
1993	99.0	1.0	94.1	5.3	0.7
1994	99.0	1.0	93.9	5.5	0.6
1995	99.0	1.0	93.5	5.9	0.6
1996	99.0	1.0	92.9	6.5	0.6
1997	99.1	0.9	92.4	7.0	0.6

*Includes free-standing birth centers.

Sources: U.S. Department of Health and Human Service, *Vital Statistics of the United States*, Vol. 1: *Natality* (Hyattsville, MD, U.S. Department of Health and Human Services, 1993); National Center for Health Statistics, "Advance Report of Final Natality Statistics, 1990," *Monthly Vital Statistics Report*, Vol. 41, No. 9, 1993 (supplement); National Center for Health Statistics, "Advance Report of Final Natality Statistics, 1991," *Monthly Vital Statistics Report*, Vol. 42, No. 3, 1993 (supplement); National Center for Health Statistics, "Advance Report of Final Natality Statistics, 1992," *Monthly Vital Statistics Report*, Vol. 43, No. 5, 1994 (supplement); National Center for Health Statistics, "Advance Report of Final Natality Statistics, 1993," *Monthly Vital Statistics Report*, Vol. 44, No. 3, 1995 (supplement); National Center for Health Statistics, "Advance Report of Final Natality Statistics, 1994, *Monthly Vital Statistics Report*, Vol. 44, No. 11, 1996 (supplement); National Center for Health Statistics, "Report of Final Natality Statistics, 1995," *Monthly Vital Statistics Report*, Vol. 45, No. 11, 1997 (supplement); National Center for Health Statistics, "Report of Final Natality Statistics, 1996." *Monthly Vital Statistics Report*, Vol. 46, No. 11 1998 (supplement); National Center for Health Statistics, "Births: Final Data for 1997," *National Vital Statistics Reports* Vol. 47, No. 18, 1999. See also S. Curtin and M. Park, *Trends in the Attendant, Place, and Timing of Births, and in the Use of Obstetric Interventions: United States*, 1989–97. Hyattsville, MD: National Center for Health Statistics.

TABLE 2. Distribution of Live Births By Place of Delivery and Attendant, 1940–1996, the Netherlands (in percent)

Year	Place of delivery		Attendant*	
	Hospital†	Home	Physician	Midwife
1940	n/a	n/a	51.3	47.7
1945	n/a	n/a	62.8	36.1
1950	n/a	n/a	58.1	41.1
1955	23.9	76.1	58.5	40.9
1960	27.4	72.6	63.0	36.6
1965	31.5	68.5	64.2	35.3
1970	46.7	57.3	62.7	36.7
1975	55.6	44.4	59.9	38.6
1980	64.6	35.4	59.7	39.4
1985	63.4	36.6	57.8	41.7
1990	67.9	32.1	53.9	44.1
1992	68.5	31.5	53.1	45.8
1993	69.3	30.7	52.9	46.4
1994‡	65.7	33.8	n/a	n/a
1995‡	65.5	34.1	n/a	n/a
1996‡	63.6	35.8	n/a	n/a

n/a: not available.

*Excludes births with shared responsibility and cases where attendant is unknown.

†Beginning in 1970, includes "polyclinic" (i.e., short-stay) hospital births. *Sources*: Centraal Bureau voor de Statistiek, 1899–1989, *Negentig Jaren Statistiek in Tijdreeksen* [Ninety Years' Statistics in Series] ('s-Gravenhage, CBS Publikaties, 1989); Centraal Bureau voor de Statistiek, *Geborenen Naar aard Verloskundige Hulp en Plaats van Geboorte* [Births by source of obstetric help and place of birth] (Voorburg, CBS, 1990, 1992).

‡Data for 1994, 1995, and 1996 are from the "Health Survey," as reported in *Vademecum of Health Statistics of the Netherlands*, Centraal Bureau voor de Statistiek, 1998 (p. 98). See also P. Offerhaus, K. van der Pal-de Bruin, and S. Buitendijk, *De Thuisbevalling in Cijfers* (Home Birth in Numbers), *Tijdschrift voor Verloskundigen* Vol. 24, No. 11 (1999):742–745.

Dutch midwives are renowned for their high degree of autonomy. In many other countries the scope of midwifery practice is limited by statute: midwives must work under the direct supervision of a physician. Midwives in the Netherlands are primary caregivers who work independently; they are defined by statute as "medical," rather than as "paramedical," practitioners. Midwives are free to diagnose and treat their clients and to decide when a referral to a specialist is necessary. The autonomy of Dutch midwives rests on two things: (1) an extensive and well regarded education program and (2) a set of guidelines known as the Obstetric Indications List.

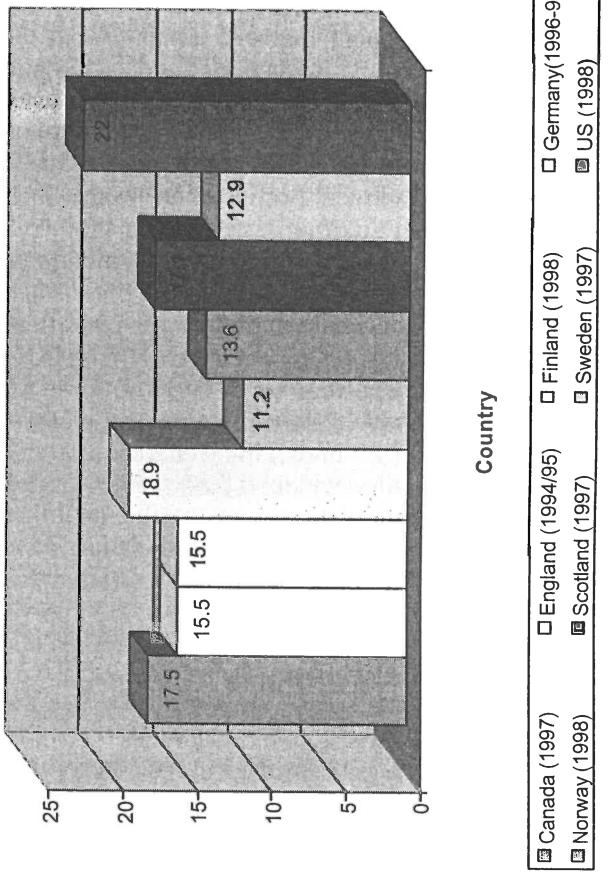

Figure 1:. Cesarean Section Rates (Number of Procedures Per 100 Births), Selected Countries (Declercq and Viisainen, 2001).

Dutch midwives are among the best educated midwives in the world. Interestingly, midwifery education in the Netherlands is not university-based. Would-be midwives complete five years of secondary schooling and then apply to one of the three schools of midwifery, which are part of the Dutch *Hoger Beroeps Onderwijs* (HBO) (Higher Occupational Education) system. Because the number of applicants far exceeds the number of places available, the schools use a modified lottery system to select those who are to be admitted: candidates are screened and those who are approved are put into a pool from which names are drawn. The educational program is four years long[17] and includes training in antenatal and postnatal care, normal low-risk deliveries (both at home and in the polyclinic setting), the identification of high-risk situations in the antepartum, intrapartum and postpartum periods, and techniques of scientific research. There are some who believe that the status of midwives would be enhanced and protected if midwifery education moved into the university, but my research suggests that being located outside the university has allowed midwives to protect their special knowledge and, thus, their autonomy.

The autonomy of midwives is further protected by the mandated cooperation that is built into the Dutch system. The *Verloskundige Indicatielijst* (VIL) (Obstetric Indications List) defines the conditions that require midwives and general practitioners to refer their clients to specialists.[18] The list was first suggested by de Snoo (1930) in his *Leerboek voor Verloskunde* (Textbook of Obstetrics). In the late 1950s, at the request of the *Ziekenfondsen* (Sick Funds), the well known Dutch gynecologist Gerrit-Jan Kloosterman developed the list further; and, in 1973, an expanded version of the VIL appeared in his textbook, *Leerboek voor Obstetrie en Gynaecologie: De Voorplanting van de Mens* (Textbook of Obstetrics and Gynecology: Human Reproduction) (Kloosterman 1973). The Kloosterman List, as it came to be known, was endorsed by all professors of obstetrics in the Netherlands and was recommended for use by medical insurance companies.

In the late 1970s and early 1980s a government agency, the *Ziekenfondsraad* (Sick Funds Council) (see section on "Politics" for more information on the *Ziekenfondsraad*), began the move toward formalizing the list by convening various commissions to review current practices and to recommend a way to better promote the coordination of maternity care services. In 1982 the *Ziekenfondsraad* organized the *Werkgroep Bijstelling Kloostermanlijst* (WBK) (Work Group for the Revision of the Kloosterman List), which generated

the first "official" list. Among the reasons the government decided to move to a formal list was a worrisome increase in hospital births and large regional variations in maternity care, which "[created] the impression that in some cases the medical indication [for hospital birth] was possibly requested for the wrong reasons." (*Ziekenfondsraad* 1987:10). Both the Dutch government and Dutch midwives were concerned about the precipitous drop in home births during the 1970s: the rate declined from nearly 60 percent in 1970 to just over 35 percent in 1980 (see Table 2). The government was worried about the unnecessary costs associated with hospital care for "normal" births; the midwives feared their autonomy would be compromised if most of their work was conducted in bureaucratic hospital settings.

In 1987 the WBK presented the result of its work and the official VIL was established.[19] The *Nederlands Vereniging voor Obstetrie en Gynaecologie* (NVOG) (Dutch Association of Obstetricians and Gynecologists) was not altogether pleased with the list and refused to officially endorse it. Nevertheless, it became the document that governed the policy decisions of the government and the insurance companies (see Riteco and Hingstman 1991). In the mid-1990s a new work group was formed, and it produced a modified version of the list that has been approved by all professions delivering maternity care (see *Ziekenfondsraad* 1999). As I will explain below, the VIL, in its various manifestations, has created boundaries around practices that allow midwives and physicians to stake out areas that are uniquely theirs.

DUTCH MATERNITY CARE: THE FACTORS BEHIND THE SYSTEM

The Dutch maternity care system presents an intriguing problem for us Anglo-American social scientists: clearly something different is going on here, something that requires us to rethink our easy analysis of maternity care in other countries. In the United States, for example, there is good evidence to suggest that the structural and cultural power of physicians conspired to suppress, if not to eliminate, midwifery. Midwives were not only chased from practice by doctors who did not appreciate the competition, but the polished image of American medicine created a situation that caused immigrant women to abandon their midwives and to seek the care of

"modern" medical men (see Borst 1995). In the Netherlands, this "medical hegemony" explanation does not work as well. If we want to save the theory and use it to explain the situation of Dutch midwives, then either we need to come up with a new, more flexible definition of hegemony or we need to create a tortured explanation that shows how physician support of a competing occupation serves the long-term interest of the medical profession. Neither of these alternatives is practicable. One might argue, for instance, that the interests of physicians are advanced by supporting midwives because the latter can then handle the "dirty work" of obstetrics, attending the "boring," uneventful, normal births. But that argument introduces other variables that quickly complicate the hegemony explanation: now we must explain why some physicians classify normal birth as "dirty work" while others do not. Having explained that difference, we then face the false consciousness problem: the hegemonic doctors who consigned normal births to midwives must have been unaware that their decision would, in fact, diminish their power.

Dutch maternity care also confounds our understanding of the relationship between technology and society. The idea of the "technological imperative" (i.e., if the technology exists, then it will be used) is widely accepted by both academics and the public. We need not look far for "proof" of the technological imperative: experts and non-experts alike see the rapid proliferation of the sometimes useful, sometimes annoying, cellular phone as ample evidence that technology always makes a way for itself, even if it violates established rules of etiquette (and safety). In the world of medicine and maternity care there are numerous examples of technology forcing its way into, and sometimes disrupting, the relationship between clients and practitioners. Magnetic resonance imaging replaces consultations about migraines, and electronic fetal monitoring (EFM) takes the place of regular and reassuring visits from the obstetric nurse. Indeed, most studies of care at birth, even those carried out in remote societies, regard complete hospitalization and increased technological intervention as the logical and unavoidable result of the application of modern science to the "problem" of birth. But here again the facts of Dutch maternity care do not cooperate. The Netherlands is as technologically sophisticated as any modern nation, and yet midwives and general practitioners (who attend approximately half of all births in the Netherlands) use very few "modern" technologies. Midwives do

not encourage prenatal testing (see Rothman 2001), and they eschew the use of EFM, using fetoscopes instead.[20]

Social scientists and historians have given much attention to the development of maternity care, particularly in the United States and England (see, for example, Arney 1982; Wertz and Wertz 1977; Sullivan and Weitz 1988; Leavitt 1986; Rothman 1982; Litoff 1978, 1986; Donegan 1978; Donnison 1977; and Oakley 1980, 1984). These studies – conducted, for the most part, in the late 1970s and 1980s, when interest in the role of women in society was at its peak – saw maternity care as an arena in which the struggle between the sexes was played out and in which medical men emerged the victors. The titles of many of the studies reflect the emphasis on struggle, power, and domination. We learn of "captured wombs," of "women confined," of "misogyny." Often the labor of childbirth becomes a metaphor for a larger struggle: consider *In Labor: Women and Power in the Birthplace* (Rothman 1982) or *Labor Pains: Modern Midwives and Home Birth* (Sullivan and Weitz 1988). These books create the impression that the history of childbirth care can be reduced to the study of inter-professional, inter-gender rivalry. They tell us much about the place of women and their treatment as maternity patients, but we learn little about the way other features of society – the organization of health care, societal views of the body and its abilities, ideas about health and illness, ideas about the role of medical treatment in the course of life – affect the structure of obstetric care. Because it does not fit with the generalizations offered in these books, the maternity care system of the Netherlands forces us to revise and expand our explanations of the relationships between professions and between professionals and their clients.

Rothman recognizes the challenge presented by the oddity of Dutch obstetrics. In her description of birth in the Netherlands, she says: "[it] is so fundamentally different that all our taken-for-granted assumptions may be challenged" (Rothman 1993:203). This necessarily includes our social scientific assumptions. However, in this challenge lies opportunity. The uniqueness of Dutch maternity care allows us to deepen our understanding of the field of midwifery and its place among other professions. Unfortunately, an explanation of Dutch maternity care requires an understanding of a bewildering array of facts, including (among others): cultural notions of women, men, parenthood, and families; the operation of health care delivery systems and health care financing; the history of health professions and their relation to each other and to the political system; ideas

about the body; the role of religious values; the working of economic systems; and geography. In the short space of this article, I cannot explore each of these phenomena in depth.[21] Therefore, in the following pages I present a somewhat simplified explanation that revolves around just four of them – geography, health care organization, politics, and culture. I offer a short description of how each phenomenon has affected the current status of midwives in the Netherlands. My intention is to be provocative, to encourage further reflection on the status of midwives, and to challenge the assumptions that Anglo-American social scientists hold dear.

Geography

In looking at the variety of social structures that support Dutch maternity care it is easy to overlook the obvious fact that the system needs a physical infrastructure in order to survive. Perhaps the simplest explanation of the continued use of home birth and midwives in the Netherlands is the geographical one. The Netherlands is a small, flat, densely populated country where one is never far from a hospital. Home birth attended by midwives is feasible in this landscape – where a mother can be easily and quickly transferred from her home to the care of a specialist – in a way that it is not in the vast expanses of the United States or in the rugged terrain of Norway. Nearly all of my interviewees included the geography of the Netherlands, the quality of its roads, and the location of its hospitals among the reasons for the continued presence and success of the unique Dutch obstetrical system. The importance of geography to the success of Dutch obstetrics is reflected in the concerns of home birth advocates over the government decision to consolidate specialists' practices and to close smaller hospitals. Jouke van der Zee (2000, personal communication), the director of a large health care research organization in the Netherlands and a supporter of the Dutch obstetric system, observes:

> home birth in the Netherlands is threatened by ... the process of concentration of gynecologists and pediatricians/neo-natologists in bigger groups and more specialized hospitals which leave the common general hospital without sufficient expertise in the domain of specialized birth care. This is a real threat to home deliveries because the hospital next door might not be available in the case the delivery at home meets complications.

In his inaugural address, celebrating his appointment as professor of obstetrics at the University of Maastricht, J. G. Nijhuis (2000:17) offered the same prediction, saying that the closure of small hospitals (as a result of mergers) and the consequent increase in the distance between home and hospital makes home birth "irresponsible":

> Minister [of Health] Borst has already said that we in the Netherlands must return to a maximum of 40–60 hospitals and this will have immediate consequences. The distance to the large, consolidated hospitals shall become such that home birth in parts of our country will become irresponsible. Transport during the birth, for example, will become more complicated and take longer because of the increase in traffic congestion.

In its report on Nijhuis's address, the *Nederlands Dagblad* (2000) summarized his comments in this colorful phrase: "Mergers in the hospital world are 'choking the neck' of the Dutch system of home birth."

Clearly, geographic conditions are important to the Dutch way of birth. However, geography is only a necessary condition for the preservation of home birth, it is hardly a sufficient cause. Having "conducive" geography, or ways of overcoming geographic problems, is not enough to ensure that many women will give birth at home rather than in the hospital. After all, other small countries (e.g., Belgium) have eschewed birth at home. Therefore, in order to understand the relatively slow movement of Dutch births from the home to the hospital we must look beyond geography.[22]

The Dutch Health Care System

In his effort to explain the Dutch way of birth, Hingstman (1994) calls our attention to three structural features of health care in the Netherlands that support home birth: (1) the special protected position of the midwife, (2) a risk-screening system for pregnancies, and (3) a well organized program of maternity home care. I briefly discussed all three of these in my description of Dutch obstetrics; I now consider their role in preserving home birth and the autonomous profession of midwifery.

Midwives – the primary attendants at domiciliary deliveries – have a well established and protected place in Dutch health care. Unlike midwives in other European countries, Dutch midwives had access to education and certification very early on. Beginning in the second half of the 17th century, local medical societies set up training programs and methods of examination and approval for midwives. In 1818, the first national law regulating midwives was passed,

affirming the place of midwives as legitimate and appropriate providers of care at birth; in 1865 a law defining the practice of medicine established midwives as independent medical practitioners (Marland 1993:26–29).

The current health care system was put in place by a law passed in 1941, and it is this law that gives midwives the "protected" position to which Hingstman refers. I have already described the *primaat*, referred to by some as a "monopoly over normal obstetrics" (Abraham-Van der Mark 1993:4): the law stipulates that when pregnancy and birth proceed normally, insurance will pay only for care in the *eerstelijn*, and then only for the care of a midwife, if one is available. It is possible, as the result of a suit brought by general practitioners (see Note 14), that the *primaat* will soon be abolished; however, even without it, the organization of Dutch obstetrics shows a clear preference for domiciliary care offered in the *eerstelijn* (by midwives and general practitioners) over the high-tech ministrations of specialists in hospitals.

The law governing the practice of medicine makes a distinction between normal ("physiological") and high-risk ("pathological") births. The VIL represents the formal encoding of this screening system, and it allows the Dutch to avoid the assumption made in most other industrialized countries; that is, that *all* births are "potentially" pathological, or "high risk," and that, therefore, they must be monitored by specialists in hospitals. The position of midwifery is necessarily weakened in obstetric systems within which all births are assumed to be fraught with unpredictable danger.

In their day-to-day negotiations with gynecologists, Dutch midwives have become quite adept at translating the formal power given them by government regulations into a more informal source of control. Midwives with a less favored position in the rules governing health professions must resort to "strategies of subversion" in order to gain power in the workplace. For example, nurse-midwives in the United States have found ways to keep women walking during labor, to do perineal massages, and to provide food and drink to laboring women in spite of hospital regulations that prohibit these practices (see DeVries and Barroso 1997). Dutch midwives, being legitimate and respected members of the *eerstelijn*, have little need for these subversive tactics.

The formal arrangements of the VIL suggest that gynecologists are the ultimate advice-givers: even though midwives and gynecologists negotiate as colleagues, the last word – formally – belongs to the specialist. But midwives are well aware of how to use their power of referral – remember that the Dutch health care system mandates that specialist care be given only on referral from the *eerstelijn* (i.e., a midwife or a *huisarts*) – to gain control over the behavior of gynecologists. If a midwife believes a gynecologist is treating patients poorly or is actively discouraging women from getting their babies at home, then she can simply cease sending women to this specialist. Eventually the gynecologist being shunned will notice and will call to ask what might be done in order for her/him to receive referrals once again. This strategy works best in areas where several hospitals are competing for clients, but even midwives in rural areas report traveling extra distances to avoid undesirable practices in local hospitals. A midwife explains:

[DeVries:] How would you characterize your relationship with gynecologists?
[Midwife:] Good . . . Because we have more hospitals here. It means that you can bargain with them. You can more or less do what you want to do as long as you give care. But you can make your own decisions.
[DeVries:] What does that mean: "to bargain with them?"
[Midwife:] Like, for instance, if there is somebody who has a third-degree tear . . . a few years ago, in the one hospital the women could be sutured and then they could be sent home. And in another hospital they'd have to stay for a whole week. Which is very old-fashioned, but nobody ever challenged that. So then I had somebody with a third-degree tear, and I called the hospital where she had to stay for a week, and I said to them "She wants to come to your hospital, but . . . if she goes [to a competing hospital], she can be sutured and then she can be sent home. Could you do the same thing in your hospital?" At first they said "No," and when I asked them again they said, "We haven't talked," and then the third time they said, "Yes, all right." . . . That's how you can bargain with obstetricians . . .
If we cannot get something from one hospital, we'll go to another hospital and we'll negotiate. And then we'll let the first hospital know that we negotiated with the other hospital, so would they also let us have the same.
[DeVries:] And if not you won't be coming there.
[Midwife:] *Ja*. Strong, eh?

Another midwife, in a different city, describes the same strategy:

I work with three hospitals, and one of those hospitals was boycotted for years and years. We refused to go there. We told the patients: "No, we are not going to . . ." Because we did not like the way the gynecologists practiced. Because, for example, you had a delivery, you sent the woman there,

let's say with a few centimeters dilation, and then you'd come there, after a few hours, and the baby could have been born with a vacuum. They just interfered... we refused to work there.
A few weeks ago there was a new gynecologist starting to work there; a woman who comes from the AMC [Amsterdam Medical Center] and had worked in Alkmaar. And they had a reception, to introduce her, and at that reception they really were on their knees... If we, please, would we come back? And they wanted to change everything, and things would never be done this way again, and they... and they would do everything we wanted...
And we were sitting there, a lot of midwives were there, and we put a lot of questions... "Will you stop that? And won't you do that? And is it possible to do this?"
[DeVries:] So the boycott worked?
[Midwife:] Ja.

Midwife-assisted birth at home is also made possible by the well organized system of maternity home care described above. Postpartum care at home is available to home-birth mothers and to those who have a polyclinic birth. With a nominal co-pay – where the client pays a small portion of the cost of services – a new mother is entitled to up to 64 hours of care by a *kraamverzorgster. Kraamverzorgsters* follow a three-year training program and offer a range of services, including newborn care, help in initiating and sustaining breastfeeding, health advice for mother and child, and help with housework (Van Teijlingen 1990). Without the intra- and postpartum care given by *kraamverzorgsters*, it would be impossible to maintain the current number of home births and short-stay hospital births: midwives would be tremendously overworked and women choosing these options would feel short-changed (Hingstman 1994; Van Teijlingen 1993).

These structural features of Dutch health care are a good starting point for explaining the continued use of midwives and home birth in the Netherlands, but I cannot end my analysis here. I must now examine how this structure came into being. In other words, I must look at the arrangements of power – the politics of health care in the Netherlands – that generated this system.

Politics

Some of the harshest critics of home birth in the Netherlands are Dutch gynecologists; admittedly, the international obstetric community has a healthy skepticism toward the Dutch way of birth, but it is gynecologists practicing within the Dutch system that have

provided nearly all of the published critiques of maternity care in the Netherlands (see, for example, T. Eskes 1980, 1992; T. Eskes et al. 1981; Lievaart and de Jong 1982; Hoogedoorn 1986). Not only have these specialists criticized their obstetric system on the pages of international journals, but, as noted above, until 1999, their professional organization, the NVOG, refused to ratify the revised VIL, believing it gave too much power to midwives and general practitioners. The lack of NVOG endorsement did not prevent the government and insurance companies from using the VIL, a fact that many students of the professions will find perplexing. How can it be that a prestigious group of medical specialists lacks the power to shape government decisions in a way that favors their interests? In the United States those who wish to see midwifery and the opportunity for home birth expanded have been repeatedly defeated by powerful medical lobbies (DeVries 1996).

Dutch gynecologists are unable to use the government to protect their profession because the Dutch political system and the Dutch government are organized to prevent powerful interest groups from dominating policy making. The Dutch have a parliamentary government, with seats allocated to a variety of political parties in proportion to the percentage of votes received in the general election. This system allows a large number of political parties to be active in government and necessitates coalition building and negotiations and alliances between groups. Unlike a two-party system, this form of government assures representation of a variety of interests and makes targeted lobbying difficult.

The Dutch system of governing also makes it hard to translate money into influence. For the most part, membership dues support political parties. Some parties receive business donations, which they must declare; however, individual members of parliament may not accept such donations.

Mirroring the structure of politics, government agencies that create health policies are carefully organized to give representation to all parties with a vested interest in health care. The *Ziekenfondsraad* (Sick Funds Council) is perhaps the best example of this democratic representation. This council makes important decisions about what sort of care will be offered, by whom, and for what fee. By statute, the membership of this council includes representatives from employers, unions, caregivers (of all sorts), hospitals, patient organizations, insurance companies, and the government. Each representative has an equal voice, and decisions are reached through

negotiation and compromise.[23] Thus, if the NVOG wished to move all births to the hospital they would have to argue, on equal footing, with all those who wish to protect the choice to give birth at home, including Dutch midwives, consumer groups, insurance companies, and government officials.[24]

This brief description of politics and policy making in the Netherlands advances our understanding of Dutch obstetrics, but it also creates new questions: Why do the Dutch favor negotiation and compromise? Why is home birth a practice that some sectors of Dutch society (including the government) feel is worth preserving? After all, no one in the Netherlands is insisting on preserving the once widely used practice of conducting minor surgery at home. In order to answer these questions we must examine the role of culture in the organization of medical systems. Are there peculiarities in the culture of the Netherlands that explain its continued use of home birth?

Culture

To suggest that there may be something we can identify as "Dutch culture" and that it may have some effect on the way health care is organized and delivered is to open an anthropological can of worms that was tightly sealed four or five decades ago. The idea of "national culture" has been poorly developed and often misused; to posit a static national culture is to ignore the fact that culture is emergent, negotiable, varied. And, in fact, it is not difficult to find naïve conceptions of culture being used to explain the unique Dutch way of birth. Kloosterman offers an amusing report of a cultural explanation of Dutch home birth that was given by a few members of the British parliament who were visiting an academic hospital in Amsterdam:

> To my great surprise, they suggested that the fact that so many Dutch women had their babies spontaneously, without any anesthesia, was related to our Calvinism. The Calvinist view is to give birth to children in sorrow. The Dutch would keep anesthesia from women in labor because of the Old Testament. That idea never occurred to me before. It is an interesting viewpoint, but it is not mine. It is obvious that we try to make childbirth as pleasant and painless as possible. (cited in van Daalen and van Goor 1993:194)

Notions of national culture have an undeniable tendency to oversimplify the complex and competing systems of meaning in a society, but to discard them completely is to ignore their contribution

to human interaction. In his analysis of the stereotyping of Dutch society, van Ginkel (1997:39) casts a wary eye on the characterizations of the Dutch made by tourists and armchair social scientists, and yet he insists that there are observable and important differences between national cultures:

> Often firmly held opinions [about the character of the Dutch] are confirmed by a very thin selection of data. Nevertheless, [the Dutch] feel or experience, in a general sense, separation from people of other nationalities and cultures . . . It is this subjectivity, it is these we-feelings, that color our self image and our images of others . . . It is not for nothing that we in the Netherlands so often speak of "we" and "ours." There may be talk of a globalizing process, such that national boundaries are erased, but still we are confronted with cultural differences, for example, concerning time consciousness, manners, norms, eating habits, codes of communication, political arrangements, and so forth.

The danger of over-simplification should not lead us to overlook the importance of culture with regard to how life (including the delivery of health care) gets organized. In fact, the Dutch have a variety of cultural ideas that distinguish them from neighboring lands – ideas that have important consequences for their view of the appropriate way of accomplishing birth.

Dutch views of the "family" and of the role of women in the family are distinctive. The Dutch were the first among modern nations to experience the "nuclearization" of the family. According to van Daalen (1993, 1988) the Dutch family nuclearized in the late 17th and early 18th centuries, earlier than in the other nations of continental Europe. And, in comparison to other European states, family life in the Netherlands in the 16th and 17th centuries was rather peculiar. During that period the bourgeois model of the family – a model that prized motherhood and expected all women to become wives and mothers and to care for children, do the cooking and the laundry, and keep a clean home – became the prevailing family form across all social classes in the Netherlands (Pott-Buter 1993:48). And yet, contrary to what might be expected, Dutch women enjoyed remarkable freedoms. Unlike their sisters in other European countries, Dutch women could make "commercial contracts and [notarize] documents and had the formal qualifications needed for active commercial business dealings" (Pott-Buter 1993:66). Schama (1988:402–403) reports that travelers in the Netherlands were "disconcerted" by "the apparent freedom that apparently respectable

Dutch women enjoyed in comparison with their contemporaries elsewhere":

> Public kissing, candid speech, unaccompanied promenades all struck foreigners, and especially the French, as shockingly improper, even though they were repeatedly assured of the impregnable chastity of the married woman... Outside the house women assumed an informality that seemed much too audacious for their own good. At the end of the sixteenth century, Fynes Moryson had been aghast at Frisian women embracing and defecating in public, assuming regular control over the family budget, skating at night until the city gates were locked, and most astonishing of all, feasting through the night in taverns ten or twenty miles from home.

In seeking to explain this paradox of freedom and restriction, historians look to the character of the marriage relationship. As the wives of farmers, fishers, and traders (the primary occupations in the Netherlands), Dutch women assumed a great deal of responsibility for managing the family and its resources. This gave them unique privileges, although always within the context of the family. With its emphasis on affection as the core of marriage, Dutch Calvinism also contributed to the unique position of Dutch women in the family. According to Schama (1988:421, 424):

> At the core of the [Dutch] marriage bond was affection, tenderhearted sentiment, love... Calvinist teaching, at least in Holland, did not at all subordinate love to obedience but rather exalted it as the indispensable quality for a godly union... Most modern historians of the family have assumed an evolution from "patriarchal" to "companionate" styles of marriage, and have busied themselves with tracking experience along a line drawn between that point of departure and its destination. By these lights, the seventeenth century Dutch seem to have been indeed pioneers on the frontier of friendly, loving marriages.

Several observers have pointed out that the historically high fertility rates of Dutch women and their low rates of participation in paid labor are the result of these distinctive features of Dutch family life, where there was a strong identification of femininity with home and with the nuclear family—known in Dutch as the *gezin* (see Pott-Buter, 1993).

How does this history relate to the position of midwives and the preference for home birth? It is perhaps too simple an explanation to suggest that women's strong and independent place in the family resulted in their jurisdiction over birth, supervised by midwives at home. Van Daalen (1988), a Dutch sociologist, offers a more nuanced explanation. She believes that the early nuclearization of the family hindered the hospitalization of birth. In other European countries the nuclearization of the family occurred simultaneously with industrialization and was marked by the increasing use of professional help for events once attended by family members: birth, sickness, and death. Having nuclearized earlier, the Dutch family resisted the institutionalization of birth and death (van Daalen 1988:432):

> Institutional birth [which was becoming popular in the early 19th century] did not fit well in Dutch society... in 1826, the Rotterdam city council declared the "national character" to be in opposition to the establishment of maternity clinics...
> Dutch family life was organized in a way we call "modern," far before the emergence of professional groups and institutions that, in the last 100 years, have become closely involved with the cares and concerns of the modern family and that... have undermined the autonomy of these families. Could it be that the Dutch have developed a family culture that offers more possibilities to resist such professional interference?

Van Daalen (433–434) claims that this tradition is also responsible for the slow movement of married women into the paid labor force, their limited use to professional childcare, and the less than generous policies for maternity leave in the Netherlands. Other observers have commented on the distinctively important role of the family in shaping the character of Dutch society. Writing in the late 1960s, Goudsblom (1967:136–137) asks himself if the Dutch family still possesses any "typically Dutch" features:

> This is a precarious question; the simplest answer would be to repeat that *the* Dutch family does not exist. This, however, seems too easy a way out. After all, there is a common stereotype that the family in the Netherlands plays a more prominent role in social life than in neighboring countries. This stereotype, moreover, can be supported by some official figures: for example, there are fewer cafés in the Netherlands and people go less often to the cinema. Such figures reinforce the generally shared assumption that the Dutch seek comfort first of all in the family, that they cherish the private rather than the public sphere... Within the narrowly confined domestic circle [women cultivate] the virtues of primness and neatness and the pleasures of homely coziness or "*gezelligheid*."

Domestic confinements also fit well with Dutch ideas about home. According to Rybcinski (1986), the Dutch are responsible for our current notions of "home" as a place of retreat for the nuclear family.

The Dutch were the first to develop single-family residences – small, tidy, well-lit homes – ideally suited for the *gezin*. The importance of the nuclear family, coupled with the domestic role of women and the tidiness of their homes, made home the logical place for birth. When you ask Dutch women and men why they prefer birth at home to birth in the hospital they will often reply that home birth is more *gezellig*. *Gezelligheid* is often translated as "coziness" (note Goudsblom's translation above); however, there is no single English word that captures the full meaning of the term. Cozy comes close, but *gezellig* also implies warmth, affection, contentment, enjoyment, happiness, sociability, snugness, and security. For the Dutch, birth at home is *gezellig* in a way that birth in a hospital can never be.

Home birth is further supported by Dutch ideas about medicine, science, and "thriftiness." The Dutch are not quick to seek medical solutions to bodily problems, a fact evidenced by their low use of medications compared to other nations in the European Union (see van Andel and Brinkman 1997:153). Furthermore, Dutch public policy is characterized by very rationalist ideas about the use of science in the formation of public policy, leading to the avoidance of moralistic stances and to an institutionalized willingness to experiment with new approaches, testing their efficacy and efficiency. This frame of mind shapes Dutch policy on soft drugs, on prostitution, on euthanasia, and on the location of births. The government has funded many studies to examine the safety, cost, and desirability of home births and has made policy decisions based on those studies (see, for example, M. Eskes 1989; Wiegers 1997). The most recent of these studies openly acknowledges that it was initiated because of a concern that "the steadily decreasing number of home births... threatened to diminish the home birth rate to a level where home birth would no longer be a viable option [and that] the increasing number of hospital births would lead to unnecessary medicalisation of pregnancy and childbirth" (Wiegers 1997:1). Visible in these concerns is another feature of Dutch culture, *zuinigheid*, or thriftiness, which inclines the Dutch to preserve home birth as a less expensive option in maternity care.

Although critical of the British use of Dutch culture to explain the persistence of home birth, Kloosterman is not opposed to cultural explanations of obstetrics in the Netherlands. In a 1966 article he characterized the Dutch as "domestic, sober, adverse to showiness, not fearful of pain and discomfort, and thrifty" (Kloosterman 1966:1816). Likewise, Rottinghuis (1947), in the journal of the association of Dutch midwives, expresses a similar opinion: "Birth is a family event (*gezinsgebeuren*) and, given the high value placed on the family (*gezin*) in the Netherlands, it must occur in that context" (cited in van Daalen, 1988:432–433).

Having identified cultural ideas that lie behind the Dutch way of birth, it is fair to ask how much explaining we can ask these ideas to do. Two caveats are in order. First, this portrayal of the role of culture in the shaping of the Dutch obstetric system does not necessarily imply that Dutch society is homogenous or that all Dutch women have identical views of family, home, medicine, and the like. Indeed, Dutch society is increasingly multicultural, incorporating a number of peoples from former colonies in Indonesia and South America as well as from Northern Africa, Turkey, and Eastern Europe. In the Netherlands, however, the majority of those who make policy are women and men who are steeped in the traditional ideas of Dutch culture, and the organization of maternity care bears the marks of that culture. The Dutch government and midwives are aware that newcomers must learn about the Dutch way of birth. More than one midwife told me about the need to point out the advantages of midwife-attended home birth to these women, many of whom see physician care in the hospital as a mark of being a modern, Western woman. The government has financed information campaigns for immigrants, using pamphlets and videos in several languages to familiarize new residents with how birth is carried out in the Netherlands (NOV, 1996).

A second caveat about the explanatory power of culture: the influence of the cultural ideas described here must be seen within the context of several other features of society. Culture is not *the* explanatory variable: it is shaped by the structures of society even as it shapes those structures. The difficulty of measuring culture and parsing out its influence, however, should not prevent us from examining the important ways in which it shapes health care systems.

THE FUTURE OF MIDWIFERY AND HOME BIRTH IN THE NETHERLANDS

One of the primary motivations for the meeting in Ede was a concern about the future of the Dutch way of birth. Now, six years later, various stakeholders in the maternity care system remain worried about the declining rate of home birth and its effect on Dutch

obstetrics. The government and health insurance companies fear that the shift to short-stay hospital births will drive up the cost of maternity care, with no consequent improvement in outcomes. Midwives continue to be concerned that the disappearance of home birth will diminish the autonomy of their profession. Organizations representing the users of maternity care fear that the choices offered Dutch women will be limited. In fact, it was concern that the declining rate of birth at home would eventually eliminate this choice for Dutch women that, in the late 1990s, prompted the creation of the first organization to promote and protect consumer interests in birth – the *Stichting Perinatale Zorg en Consumenten* (Foundation for Perinatal Care and Consumers).

In November 1999 I had conversation about the future of midwifery and home birth in the Netherlands with a well known Dutch health researcher. His comments reflect a level of concern, indeed of pessimism, shared by many. He is a strong supporter of the Dutch obstetric system and an advocate for home birth, yet he said to me: "In five years it is over ... there will be no home birth in the Netherlands." To support his prediction he quoted the German poet Heinrich Heine: "If the world should perish, I will move to the Netherlands because everything there happens fifty years later." He went on to say that Heine was right: other nations had abandoned home birth fifty years ago and now the Dutch were finally following their lead. Years ago, at the outset of my research, we had discussed this same quote and its relationship to Dutch maternity care, and he had been far more optimistic. In 1994, he insisted that Heine was wrong, he was confident that the Dutch system would not only persist, but that it would also serve as a model for others.

Are these worries about the future of birth in the Netherlands legitimate? Given the favorable geographic, structural, political, and cultural climate for midwifery and home birth in the Netherlands, and given the fact that the percentage of births occurring at home seems to have stabilized within the low 30 percent range, should supporters of the Dutch model be concerned?

Having looked at the factors that helped sustain the system, let us briefly consider the developments that are pushing the Dutch to seek maternity care in hospitals. The steepest decline in home births occurred in the 1970s (see Table 2); some suggest this move to the hospital was largely the result of a government decision to allow healthy women the option of a short-stay hospital birth.[25] But this policy decision alone cannot account for the decreased popularity of

midwife-assisted birth at home: other trends in society encouraged women and midwives to choose this option. For example, increased use of hospital birth is associated with Dutch women's increased level of participation in paid labor. It is true that Dutch women participate in the paid labor force at lower rates than do women in other industrialized countries; however, it is also true that their participation rates have risen rapidly over the past 20 years (see Pott-Buter 1993). This upward trend has resulted in an increase in older mothers (who have a greater likelihood of being diagnosed with a "complication" than do younger mothers), a decrease in fertility, and changing notions of the family and the woman's place in it. For many working women the hospital seems a convenient choice, a respite from the duties of their job and the chores of housekeeping.

Interviews with expectant parents show that Dutch attitudes toward birth are becoming more like those in other countries. When asked why they chose a polyclinic birth, parents expressed an attitude toward home and technology similar to those expressed in surrounding lands. The most common reasons for not staying home for birth are *te veel rommel* (too much mess) and the desire to have *alles bij de hand* (emergency equipment readily available) (see Wiegers 1997). Dutch women are increasingly choosing the "convenience" of institutionalized birth over the *gezelligheid* of home birth. These developments suggest that there may be a further decline in midwife-assisted home birth.

Are Dutch midwives a vestige from an earlier era? Yes and no. The peculiarities of Dutch society have allowed midwives there to preserve a kind of autonomy not enjoyed by their sisters in other modern nations. Today all the forces that have shaped midwifery in other countries exist in the Netherlands: medical technology and hospital efficiency are being used to achieve the (professional) goals of medical specialists and to meet the needs of a new generation of clients.

And yet elements of Dutch culture and the structure of health care in the Netherlands impede the drive toward more medicalized birth. Campaigns sponsored by the government, by midwives, and by consumer groups are attempting to capitalize on these unique features of Dutch society in order to prevent a faster and more complete turn from home birth and midwifery. Government support for midwifery and home birth remains strong. On 1 July 2000 a new set of regulations – promulgated by the Ministry of Health in an effort

to further promote and protect midwifery – took effect: the *norm-praktijk* (i.e., the number of births a midwife is expected to do each year) was reduced; the salaries of midwives were increased; *District Verloskundige Platforms* (DVPs) (Regional Midwife Support Offices), which will help midwives reduce the number of hours spent in activities not related to client care (e.g., negotiations with insurers and hospitals) were created; and the number of students admitted to midwifery schools was increased.

From a modernist perspective, the model of maternity care being promoted by the Dutch government and interest groups in the Netherlands appears to be a pre-modern vestige. But, in fact, this model supports a form of midwifery that combines evidence-based science with the emotional warmth and relational strength (the *gezelligheid*) of pre-modern birth. It is a form of care that replaces the traditional rationality of medicine (i.e., one that favors the professional interests of physicians) with a more "rational rationality" that legislates what is normal and pathological in birth, that clearly defines professional responsibility, and that integrates costs and medical evaluations in order to optimize outcomes with the greatest efficiency.

The Dutch way of birth is attractive to other countries. One need not look too far in the literature of obstetrics and midwifery to find articles that examine how features of Dutch maternity care might be profitably exported to other countries (see, for example, Rothman 1993; Mander 1995). The authors of these articles express admiration for the Dutch way of accomplishing birth. Oppenheimer's (1993:1402) reflection on what the United Kingdom might learn from the Dutch is typical:

> There are as many problems in the Dutch system of maternity care as in our own. The major features and philosophies of the Dutch system, however, have something to teach us – nationally agreed criteria of risk, training and support of midwives in more independent methods, and good communication and confidence between providers of primary and secondary care. Perhaps we can achieve not only low perinatal and maternal mortality and morbidity but also less dissatisfaction among consumers, more job satisfaction among midwives, and more rational working for obstetric staff.

The "Changing Childbirth" initiative in the United Kingdom – a government-supported effort to re-initiate domiciliary midwifery – (see Declercq et al. 2001) has taken much of its initiative from the Dutch system.

The story of midwives in the Netherlands reminds us how the structure of the health care system and cultural ideas about birth, gender, family, and health come together to shape the delivery of maternity care. Vestige or vanguard? Premodern or postmodern? Maternity care is a product of the culture within which it lives. The interaction between culture and health care systems can turn vanguards into vestiges – or vestiges into vanguards.

NOTES

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2. The NOV is the *Nederlandse Organisatie van Verloskundigen*. *Verloskundige* is the Dutch term for midwife, literally, "an expert in delivery," or "expert in obstetrics." The more common term (in both senses of the word – more widely used, less pretentious) is *vroedvrouw*, or "wise woman" (as in the French term for midwife, "sage femme"). In June 1998, in recognition of the 100-year existence of the NOV, the organization was "crowned" with the title *Koninklijk* (Royal); the NOV is now known as the KNOV (see Croon 1998) . See also Note 5.
3. The WVC is the *Ministerie van Welzijn, Volksgezondheid en Cultuur*, literally, "Ministry of Well-being, People's Health and Culture." *Welzijn* is often translated as "welfare"; however, in North America "welfare" has come to mean payments from the government to the poor and the disadvantaged. The Dutch word retains the broader meaning of well-being or health. In 1994, a new government was formed and made some adjustments in the different ministries, Beginning in October 1994, the ministry responsible for the people's health became the VWS, *Ministerie van Volksgezondheid, Welzijn en Sport*.
4. The title of the campaign is actually a play on words. The verb "*bevallen*" means both "to give birth" and "to please." So the title can be interpreted both as "A Good Choice Means a Better Birth" and "A Good Choice Is More Pleasing."
5. In the United States we refer to the physician specialist who provides care at birth as an obstetrician, or an obstetrician/gynecologist. In the Netherlands this person is typically called a gynecologist. Several words in the Dutch language can be used to denote an obstetrician: *obstetricus, vrouwenarts*, and *gynecoloog*, but the latter is most common. Interestingly, the Dutch word for obstetrics, *verloskunde* (literally "expertise in delivery"), is now more commonly associated with midwifery. In 1978, because of a growing number of men in the profession, the traditional name for midwives, *vroedvrouw* ("wise woman") was officially changed to *verloskundige* ("an expert in delivery"). When referring to the Dutch physician specialist in childbirth, I will follow the Dutch convention and use the term gynecologist, or *gynecoloog*.
6. Amelink and van Leent (1994) summarize the proceedings of the conference.
7. Enthusiasm about the organization of birth in the Netherlands has led to, and is fed by, exaggerated reports about what is going on there. As a result of accounts

filed after very short "fact-finding" trips to the Netherlands, many activists believe that midwives attend nearly all births there and that most occur at home (see, for example, Mehl-Madrona and Mehl-Madrona 1993). In fact, midwives attend just under half of the births in the Netherlands, and, as noted above, about one-third of births occur at home.

8. This is, of course, a brief description. For more detail see Abraham-Van der Mark (1993) or DeVries (forthcoming).
9. Women in the Netherlands do not "have" babies, they "get" (or "receive" – *krijgen*) them.
10. For more information about the role of the *huisarts* in the Dutch medical system, see van der Velden (1999) and de Melker (1997).
11. As I explain below, these choices are constrained somewhat by social policies.
12. Definitions of "healthy" and "normal" are an important part of the Dutch system. In the following section I explain how these terms are defined in the Obstetric Indication List.
13. The use of this verb, which also describes the work of a conductor of an orchestra and an accompanist for musical performances, suggests a less dominating role for the caregiver.
14. Recently, the national association of general practitioners (*Landelikje Huisartsen Verenigiing* [LHV]) mounted a legal challenge to the *primaat*. Their challenge was upheld by the court: the *primaat* was scheduled to be abolished as of 1 January 1999, but the government appealed the decision to a higher court. A decision in the appeal is pending.
15. These numbers are derived from data provided by the Dutch Central Bureau for Statistics (CBS); there is another registry of births in the Netherlands – the National Obstetric Registry (LVR – in Dutch, the *Landelijke Verloskunde Registratie*) – and, according to its data, the percentage of births in the *eerstelijn* is smaller, somewhere between 40 percent and 45 percent.
16. The data from the United States are well known, but there are a few facts about the Dutch data that many find puzzling. The reputation of the Netherlands as a "nirvana" for midwives and the last bastion of home birth will cause some to wonder at the number of midwife-assisted births and the number of home births there. Admittedly, the numbers in the Netherlands in both categories are several times higher than are the numbers in the United States; however, many are surprised to learn that midwives do *not* conduct a majority of Dutch births and that the home birth rate in the Netherlands has declined rapidly over the past three decades.
17. State-sponsored education for midwives began in the late 1800s. The original training program lasted two years; in 1920 a third year was added, and, in the 1993–94 academic year, the educational program was extended to four years.
18. See Riteco and Hingstman (1991) for a complete history of the VIL.
19. The KNOV has published an English version of the Obstetric Indication List: KNOV, Rembrandtlaan 44, 3723 BK Bilthoven, the Netherlands.
20. Many midwives use "*toeters*" to listen to fetal heart tones. Carved from wood, in the shape of a small trumpet (about six to seven inches in length), these "primitive" fetoscopes put the midwife in very close contact with her client, allowing her to use her senses of touch, smell, sight, and hearing in prenatal assessment.
21. See DeVries (forthcoming) for more detail.

22. This is not to imply that countries with less "hospitable" geographies could not create systems of home births. Most residents of urban areas in developed nations are within easy reach of hospital care.
23. It could be argued that midwives had a stronger voice on the *Ziekenfondsraad* than had gynecologists because they had one representative while the latter had one person speaking for the all the medical specialties of the *Landelijke Specialisten Vereniging* (LSV) (National Specialists Association).
24. The minister of health summarizes this situation (Borst-Eilers 1997:18): "Embedded in a long history of consensual processes of consultation and policy debate, health policies are shaped by the interaction between government and organized interest groups."
25. Ironically, the government made this decision in an effort to forestall the decline of births at home. Government officials believed that the growing popularity of gynecologist-assisted hospital births was the result of women "inventing" complications because they wished to be in a hospital. These officials reasoned that, if women with no complications were allowed to choose a hospital birth, then more of them would stay under the care of midwives and general practitioners.

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