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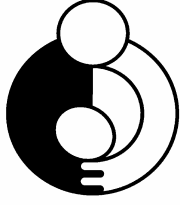
Midwifery in Europe

An inventory in fifteen EU-member states

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*Under the authority of and
in co-operation with the EMLC*



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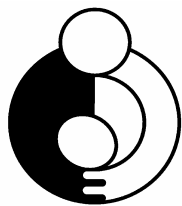
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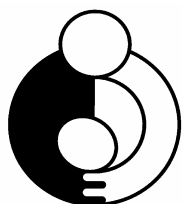
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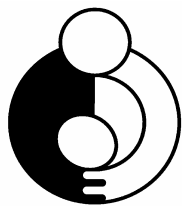


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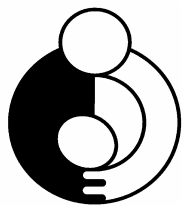
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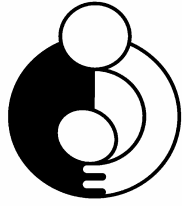
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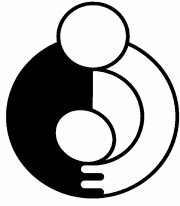


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Foreword

The European Midwives Liaison Committee, which currently meets on an annual basis, is a midwives committee representing professional associations of midwives from each of the member States of the European Union. Observer status is granted to midwife representatives in the professional associations of midwives from countries that have made an application to join the European Union and countries of the European Economic Area. The committee has links with European and global health professional organisations.

The European Midwives Liaison Committee previously carried out a survey on the Activities, Responsibilities and Independence of Midwives within the European Union. This survey, which was the first survey of its kind, taking place between 1989 and 1994, involved the then twelve Member States and was published in 1996. This document was extremely valuable.

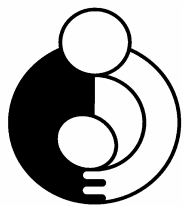
At its meeting in 2001, the European Midwives Liaison Committee considered that there was a need to review the role of the midwife in the fifteen member States of the European Union. This review commenced in February 2001 and was concluded in September 2001. The findings of this research will provide an important base, which can further embellish the midwifery profession and more importantly, will influence the care of mothers and babies in a positive way.

The deep appreciation of the European Midwives Liaison Committee has been expressed to Mandy Luiten and Josine Emons who, in a short time, produced such a comprehensive report. Their diligence is remarkable and admirable. Gratitude is also expressed to all who completed the questionnaires and who attended meetings involved in the research, especially Dorthé Taxbol, Rafael van Crimpen and Jan van Gorp. Deloitte & Touche in The Netherlands, and in particular Mr. Giljam Lokerse, who provided very generous financial assistance for this research. For this and for all their support, the European Midwives Liaison Committee thanks Deloitte & Touche most sincerely.

Anna Monaghan

President

European Midwives Liaison Committee.



1. Introduction

The report presented here is the result of research on midwifery care in Europe, carried out in co-operation with The European Midwives Liaison Committee (EMLC) and Deloitte & Touche. This study started in February 2001 and ended in September 2001.

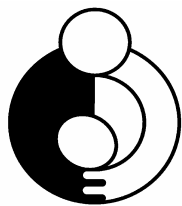
The EMLC aims to represent the interests of all midwives in Europe. To achieve this target it is necessary for the EMLC to gain an insight into the obstetric systems of all European Union member states. The objective of the research is to make an inventory of the most important characteristics of the different midwifery systems.

The survey therefore focuses on the job responsibilities and competencies of midwives, their position within the health care system, the training and statistics, such as the numbers of midwives and their income. In addition, the finance structure of the health care system in general and more specifically midwifery care are examined. Because of the occurrence of a lot of changes with respect to these subjects, some future developments have also been investigated. Based on this inventory in all the countries involved, the EMLC expects to make a declaration about the future policy concerning midwives in Europe.

The EMLC wants her members, the national umbrella organisations of midwives, to be actively involved in defining the state of affairs and the development of a future policy. That is why the organisations were asked to participate in the survey by filling in a questionnaire and attending a working conference in Amsterdam. The methods of the study will be discussed more thoroughly in the next chapter.

On the basis of the new insights collected by this survey, midwives in Europe will be able to draw up a plan to improve their position.

The report contains twenty chapters in total. In Chapter 2 the methods of the study are discussed. A brief discussion of the European directives on midwives' tasks and responsibilities is given in Chapter 3. Chapter 4 is about the definitions used in the report with regard to health care systems and finance structures. Then the descriptions of the midwifery systems follow, each country being considered separately (Chapters 5 to 19). In Chapter 20, the researchers summarise the report and make some recommendations for future research and policies.



2. Methods

The purpose of the study is to describe the midwifery systems of all European member states: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, The Netherlands, Portugal, Spain, Sweden and The United Kingdom.

The study was implemented by two researchers of Deloitte & Touche The Netherlands, supported by a working group in which the vice-president, the secretary and an advisor of the EMLC and three Deloitte & Touche consultants participated. With regard to the collecting of information, the researchers were, to a large extent, dependent on the members of the EMLC. A list with the names of all participants is attached to this report as supplement 1. The study was made up of several different phases.

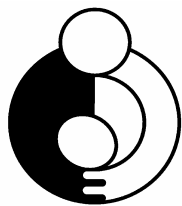
2.1 Phases

By means of desk research, the researchers tried to gather as much information as possible about the obstetric systems. Because there was limited literature available, the researchers decided to compose a questionnaire on the main features of midwifery systems. The questionnaire is attached to this report as supplement 2. All umbrella organisations of midwives were asked to fill out the questionnaire.

The subjects that were discussed in the questionnaire, are:

1. Birth and death rates
2. Care provided by midwives
3. Numbers of professionals
4. Division of tasks between professionals active in midwifery care
5. Finance structure and income
6. Training
7. Historical developments
8. Opportunities and threats.

These were also the main subjects that were presented per country at the group meeting in Amsterdam on 21 and 22 June 2001. Of the fifteen umbrella organisations, that returned the questionnaire, twelve were represented at this meeting. Only Austria, Finland and Sweden were unavoidably detained. One of the purposes of the working



conference was that each country got the chance to elucidate and comment on the presentation of his or her midwifery system. The researchers were able to gather complementary information on the subjects. Moreover, the group meeting was used to exchange thoughts about what would be an 'ideal midwifery system'. The results of this group discussion are noted partly in Chapter 20 and further noted in supplement 3.

Deloitte & Touche offices in Austria, Denmark, Germany, Greece, Italy, Sweden and the United Kingdom provided some complementary information about the financial aspects of their health care systems and midwives' income.

Having collected a lot of information, the researchers made a description of each midwifery system, which was checked by the EMLC-member concerned.

This is, in short, the description of the realisation of this report that will serve as a starting point for the EMLC's future policy. The results of the study are presented in tables as well (see supplement 4).

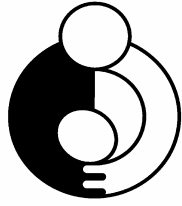
2.2 Comments

One of the pitfalls of the study is that the researchers use the Dutch midwifery system as their frame of reference, due to their Dutch origin. Therefore, the questionnaire might have contained questions and definitions based on the Dutch system, open to various interpretations by other countries. Due to this and to the linguistic problems between the countries, confusion about apparently simple definitions arose during the filling in of the questionnaires and during the group meeting.

This problem has been overcome, as much as possible, by using member-checks over and over again. Before sending the questionnaire to the umbrella organisations, it was checked by two members of the Board of the EMLC. A Dutch midwife, who has been working in Spain for several years, has critically judged whether the questionnaire was also suitable for countries other than The Netherlands. As said in paragraph 2.1, every member got the chance to comment on the final description of the midwifery system.

It should be noted that this report is not a plea for any particular midwifery system, for it recognises the reality of a range of appropriate systems. It aims to identify the main features of the different midwifery systems. Only in the last chapter, do the researchers conclude on the characteristics of a perfectly ideal midwifery system according to the umbrella organisations themselves.

Because of the use of the methods described in paragraph 2.1, the survey represents the points of view of the midwives only. The study reflects midwives' opinions on the

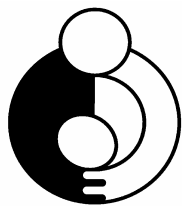


midwifery systems and its problems. This is why other professionals who are active in midwifery care might not fully recognise the system described here, as their own.

On reading the report, one might notice that not every chapter on a country contains the same (amount of) information. For example, with regard to historical developments. In those cases, no exhaustive information was available.

In this report, the physicians who are active in midwifery care are referred to as 'gynaecologists'. This term also encompasses the terms 'obstetrician-gynaecologist' and 'obstetrician' used in some countries for a physician specialising in obstetric care.

As a final comment, in the report, the midwife is being referred to as a 'she' and the gynaecologist as a 'he'. Naturally, both professions can be done by women as well as men. And so it should be read as such.



3. Midwifery in Europe

In the questionnaire, the researchers asked the countries to give a definition of a midwife. Some countries referred to the definition as stated by the World Health Organisation (WHO) or the International Confederation of Midwives (ICM). Countries also referred to the activities of a midwife as laid down in EU-directive 80/155/EEC Article 4. To prevent repetition in the report, these definitions will be described in this chapter.

The international definition of the midwife, according to WHO, ICM and the International Federation of Obstetricians and Gynaecologists (FIGO) is:

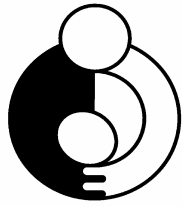
"A midwife is a person, who has been admitted and who has successfully completed an official course of studies in midwifery, duly recognised in the country in which it is located, and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery".

Generally, she is a competent care provider in obstetrics, especially trained for care during normal childbirth. However, there are great differences between countries with respect to training and tasks of midwives. In many industrialised countries, midwives function in hospitals under the supervision of obstetricians (WHO 1997).

The effect of the International Definition of the Midwife is to acknowledge that different midwifery-training courses exist.

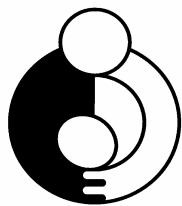
Member States of the European Union shall ensure that midwives are at least entitled to take up and pursue the following activities, according to EU-directive 80/155/EEC Article 4.

1. To provide sound family planning information and advice
2. To diagnose pregnancies and monitor normal pregnancies; to carry out the examinations necessary for the monitoring of the development of normal pregnancies
3. To prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk
4. To provide a programme for parents to prepare them for parenthood and childbirth, including advice on hygiene and nutrition
5. To care for and to assist the mother during labour and to monitor the condition of the foetus in utero by appropriate clinical and technical means



6. To conduct spontaneous deliveries including an episiotomy when required and a breech delivery in urgent cases
7. To recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor's absence, in particular the manual removal of the placenta, possibly followed by the manual examination of the uterus
8. To examine and care for the newborn infant; to take all initiatives which are necessary and to carry out immediate resuscitation whenever necessary
9. To care for and to monitor the progress of the mother in the postnatal period and to give all necessary advice to the mother on infant care, to enable her to ensure the optimal progress of the newborn infant
10. To carry out the treatment prescribed by a doctor
11. To maintain all records.

The WHO states that in many developed and developing countries, midwives are either absent or present only in large hospitals where they may serve as assistants to the obstetricians. In a few European countries, midwives are fully responsible for the care of normal pregnancy and birth, either at home or in hospital. But in many other European countries, almost all midwives (if present) practise in hospitals under the supervision of the obstetrician (1997).



4. Finance systems

In this chapter, some definitions frequently used in this report with respect to the various finance systems of health care and midwifery care specifically, will be discussed. The text presented here comes from Y.W. van Kemenade's book: Health Care in Europe (1997).

Health care coverage in Europe is essentially the concern of the countries themselves. The systems differ in organisation, financing and delivery of health care. Even if one cannot speak of a common health insurance scheme, similar benefits are included in the health care packages of all countries. All systems financing and providing health care are mixed public/private systems.

Systems of financing have a major effect upon the way a health care system operates. There are two major ways of funding health care: an insurance system and a national system (funded from tax revenues).

4.1 Insurance systems

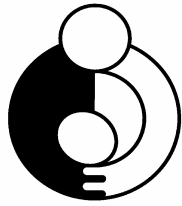
There are two kinds of insurance systems: social and private health insurance. The main difference between both systems is the extent to which the government determines the functioning of their health insurance and the nature of their demands. The systems vary in respect to the populations covered, the payments and the social services, which are included or excluded.

4.1.1 Social health insurance

General features of the social insurance system are a compulsory health insurance system, paid by employers and/or employees; public and independently controlled system; a public and non-profit making delivery of care. The group of people to whom compulsory insurance applies is established statutorily. Premiums (payroll taxes) are usually based upon solidarity (income and risk) and not on individual risk factors (age, lifestyle).

There can be reductions, exceptions or special rules for special groups, such as the disabled, the unemployed, prisoners, low-income workers and the self-employed. The premium-rate setting can be fixed by the government or by a non-governmental organisation.

A traditional national insurance system is the most influential type of social insurance, generally covering the whole population, a large insurance cover, a statutory package of benefits, an income-related premium, recompenses of 'in natura' and a reimbursement system for non-competitive executors of the insurance ('sickness funds').



Social health insurance can also have a limited benefits package (in which case supplementary private insurance exists) or cover a limited group of people.

4.1.2 Private health insurance

In a private health insurance system, the premium is mainly related to individual risk, and classes of risks are defined (age, sex, state of health, occupation). Everyone in the same risk class pays the same premium. People in different classes pay different premiums.

Private insurance is controlled by the government to a lesser extent; there is more freedom in setting the level of the premium, in defining the classes and the contents of the benefit packages. There is also competition between insurers.

In many countries, combinations of social and private insurance exist. Private insurers offer a minimum of a basic package for people excluded from social insurance. In addition, they offer supplementary benefit packages, comprising what is excluded from social security (such as co-payments, first class hospital admittance, etc.).

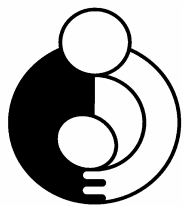
4.2 National system of (generally tax financed) health care

Features of a national system of health care are that the financing takes place through taxes and that the system is implemented by the government. Expenditure in such systems is fixed each year in parliamentary budget negotiations. The most familiar example is the United Kingdom: the National Health Service. In a national system, every citizen has the right to obtain the care that is available. There is total equity of care.

In contrast to social sickness funds, healthcare services can be provided in state-run institutions and be financed extensively via public funding.

All European countries have a mixture of finance systems. For example: private insurers exist within most national and social insurance systems. And in most countries in Europe, a combination of taxation and social health insurance payments provides the main source of finance.

Premiums and taxes can both be combined with co-payments by the citizen to the health care provider. Co-payments can be either voluntary or compulsory. They are directly linked to the individual use of health care provisions. There is no Western country with only co-payments in health care.

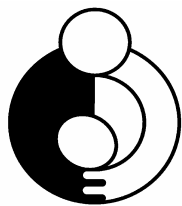


The following table summarises the characteristics of the two ways of funding health care.

Insurance system	National system
Compulsory health insurance for specific groups	Government implementation
Income- and risk related premiums	Financing through taxes
Employer/employee cost sharing	Annual budget negotiations
Statutory package of benefits	Free healthcare for all
Supplementary private insurance	Supplementary private insurance
Co-payments	Co-payments

Table 4.1: Health care financing systems

In the next few chapters, the descriptions of the different midwifery systems will be presented.



5. Midwifery in Austria

5.1 The midwife

5.1.1 Tasks and responsibilities

The job responsibilities of Austrian midwives include providing care and advice to pregnant women, women who give birth and young mothers and their babies. By performing these activities, the midwife works within the legal frame of the social medical system.

The midwife's activities are:

1. To provide family planning information
2. To diagnose pregnancies
3. To recognise abnormalities in time and to co-operate with the doctor
4. To prepare women/couples for parenthood
5. To conduct spontaneous deliveries (including an episiotomy when required and a breech delivery in urgent cases)
6. To care for the mother and the newborn infant.

By law, the midwife is responsible for normal pregnancy and birth, but in practise doctors and midwives share the responsibilities. In the case of abnormalities, the midwife refers to the gynaecologist and thereafter continues to share the responsibilities with him.

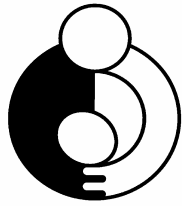
The midwife should always be present at the birth, because it is prohibited by law to give birth without a midwife.

The profession of midwifery has been protected by law since the "Bundeshebammen-gesetz" of 1984.

5.1.2 History

Between the 1940s and 1950s, the home birth-rate was 80%. But since the 1960s there have been more and more clinical births. As a consequence of this development, the home birth-rate nowadays is 2%.

From 1960 to 1970, there was a trend towards high-tech births. From 1980 to 1990, there were more alternative births.



Up to 1985, the total number of midwives was in decline; down to 20%, which was less than the number in 1970. A steady increase occurred only after 1990. Compared to 1970, 16% more midwives were active in 1998. There was also a clear shift in the way midwives were practising; in 1970, more than half were either publicly appointed or self-employed; by 1995 this number had fallen to 19%. At the same time, the number of midwives practising in hospital has risen substantially, reflecting a decline in home births (European Observatory 2001).

5.2 The midwifery system

Even though Austrian women are free to choose their care provider, 98% of all women follow the recommendations of the Mutter-Kind-Pass of 1973. This booklet recommends that all examinations during the pregnancy should be done by a doctor. So most women choose a gynaecologist to be their primary care provider. In the future, one consultation with a midwife will be added to the booklet.

Midwives are always present at the birth, but the exact percentages of deliveries conducted either by midwives or by gynaecologists are not known.

5.2.1 View on pregnancy and birth

The recommendations in the Mutter-Kind-Pass are in conflict with the natural view on pregnancy and birth in Austria. Even though both midwives and society see pregnancy and birth as natural processes, the doctor is the main care provider.

5.2.2 Division of tasks

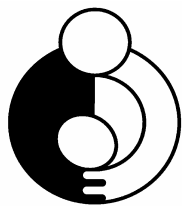
Most women are under the guidance of a gynaecologist. Sometimes, doctors refer the woman to the midwife.

Gynaecologists and midwives mainly share the responsibilities both in normal and abnormal cases.

In rural areas, some general practitioners are active in midwifery care.

5.2.3 Place of birth

Parents have a choice between giving birth in hospital, at home or in a maternity clinic. But just 2% of all births take place at home. The remainder takes place in hospital (90%) or in a maternity clinic. There are four maternity clinics in Austria; each of them takes care of no more than 100 births a year. These maternity clinics are independent institutions, which means that they are not part of the hospitals.



5.3 Number of professionals

In this paragraph the number of midwives, gynaecologists and general practitioners active in midwifery care are discussed.

5.3.1 Midwives

In Austria there were 1,550 midwives in the year 2000. Most midwives are between the ages of 20 and 40 years old.

In 1998, some 10% of active midwives were self-employed, 30% were both self-employed and working in hospitals, and almost 60% were employed solely in hospitals (European Observatory 2001).

5.3.2 Gynaecologists

In 2000, there were 590 gynaecologists in Austria.

5.3.3 General practitioners

About 5% of the general practitioners are active in midwifery. They work in rural areas.

5.4 Finance and income

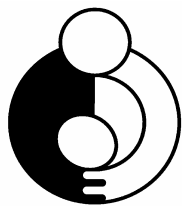
5.4.1 General insurance system

Austria is a federal state with nine autonomous provinces. The health care system consists of shared responsibilities between the federal and the provincial authorities (Länder), which is based on the federal constitution. The Federal Ministry of Labour, Health and Social Affairs is the supervising authority for the health insurance system (Van Kemenade 1997).

The social insurance system is a compulsory system and includes health insurance, pension insurance and accident insurance. The finance system is a mixture of social insurance (51%), private insurance (8%), co-payments (16%) and taxation (25%) (ibid.).

There are five social insurance laws. Participants do not have the option to select their own insurance system, because the deciding factor is membership of an occupational group. Compulsorily insured persons are covered by the following schemes:

- ASVG (Allgemeines Sozialversicherungsgesetz) for all employees and some other groups



- GSVG (Gewerbliches Sozialversicherungsgesetz) for the self-employed
- BSVG (Bauern-Sozialversicherungsgesetz) for the self-employed in agriculture and forestry
- B-KUVG (Beamten-, Kranken- und Unfallversicherungsgesetz) for civil servants
- FSVG (Freiberufliches Sozialversicherungsgesetz): freelancer's insurance

Social insurance is administered by 28 social insurance funds, which are self-governing bodies under public law (ibid.).

The health insurance schemes are financed by obligatory social security premiums. Premiums are fixed by law, are income-related and there is a maximum. Employers and employees contribute to this premium on a 50/50 basis. The income of the social insurance funds consists of the contributions (premiums) of the insured persons (88%), prescription charges (11%) and contributions from the federal authorities to the farmers' health insurance scheme (1%).

Private insurance is often supplementary. About 38% of the population have some degree of private insurance (ibid.).

5.4.2 Reimbursement

The social insurance system is based on a 'benefit in kind' system, instead of the restitution system of the privately insured.

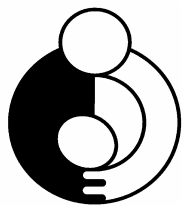
In general, pregnant woman is entitled to free treatment by a doctor and the assistance of a midwife (Vertragshebamme) during the pregnancy and after the delivery. A woman has to have a Mutter-Kind-Pass, which contains information about check-ups. The woman needs this booklet for her maternity allowance.

But it is also possible to choose a private midwife (Wahlhebamme). She has no contractual relationship with the insurers of the compulsory system. The pregnant woman pays the midwife for services rendered and has the possibility of claiming a maximum of 80% of the costs from the social healthcare system.

Furthermore, the woman is entitled to medication, reimbursement of costs for a hospital delivery and home care (Dialog met de Burgers 2001). She can also get insurance for extra or luxurious midwifery care via additional private insurance.

5.4.3 Income

Midwives are either paid a salary for employment, paid per client or paid a fee-for-service. An independent midwife can make a contract with the umbrella organisation of the social insurance associations, or if she does not have a contract, she can arrange



her fees herself and the social insurer will reimburse 80% of the amount of the fee to the client. For employed midwives, salaries are set by contracts between employers' organisations and trade unions. The average income annually for midwives working in a hospital is about €21,802.

5.5 Training

5.5.1 Admission requirements

To be admitted to the midwifery-training course, students need a university entrance qualification, except for when they are already general or children's nurses.

5.5.2 Colleges

The duration of the midwifery-training course is three years. Examples of the subjects that are dealt with are:

- Obstetrics
- Gynaecology
- Anatomy
- Physiology
- Paediatrics.

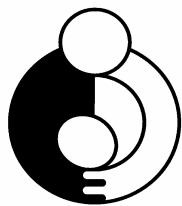
The students must complete 3,250 hours of practical experience and 1,530 hours of theoretical and technical education. The course complies with the European Union Directives. The training course goes on every three years, with 156 new students enrolling.

5.6 Developments

According to the Austrian umbrella organisation (Österreichisches Hebammen-Gremium), midwives will become increasingly competent. This will lead to new opportunities for the midwifery profession. But first there are some threats that have to be overcome.

5.6.1 Threats

Almost all births take place in hospital. This is probably due to the fact that most women choose the gynaecologist to be their primary care provider. This is maintained through the Mutter-Kind-Pass that recommends check-ups by a doctor, even in the case of normal pregnancies and births. Usually, the midwife and gynaecologist share responsibilities in both normal and abnormal cases whereas, according to the



midwives, the midwife should be the leading professional in the case of a normal pregnancy and birth.

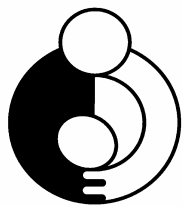
5.6.2 Opportunities

It is said that in the future, in the Mutter-Kind-Pass, one consultation by a midwife will be added. This will give the midwife a better (stronger) position in the natural process of pregnancy and birth (normal cases).

5.7 Statistics

Year	2000
Inhabitants	7,900,000
Birth-rate	77,887
Born alive	77,568 (99.59%)
Stillborn	319 (0.41%)
Perinatal mortality rate	0.50%
Midwives	1,550
Births per midwife	
Gynaecologists	590
General practitioners active in midwifery care	5.0%

The perinatal mortality is the number of stillborn and deaths weighing at least 500 grams that occur in the first week of life (Statistik Austria 2001).



6. Midwifery in Belgium

6.1 The midwife

6.1.1 Tasks and responsibilities

In the definition of the World Health Organisation, the care provided by a midwife includes: preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the implementation of emergency measures in the absence of medical help. This means that the midwife has a role in primary, secondary and tertiary prevention (WVVV 1996).

- Primary prevention entails trying to prevent illnesses. The task of the midwife is to provide information on medication, sexuality, freedom of choice, pregnancy, birth etc.
- Secondary prevention entails trying to detect illnesses or abnormalities as soon as possible. This way, further development of the disease can be prevented. The most important task for the midwife here is to detect high-risk pregnancies and to assist with antenatal screening.
- Tertiary prevention entails trying to prevent and/or to slow down diseases and to teach people to cope with a disease or abnormality. The midwife is the right person to guide the woman and her partner psychologically and emotionally (ibid.).

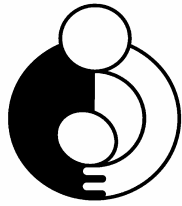
The WVVV document “Beroepsprofiel van de vroedvrouw” (Professional profile of the midwife) makes full references to the ICM/FIGO/WHO agreed definition of a midwife (1992) and the activities of a midwife as laid down in 80/155/EEC Article 4.

In Belgium, a midwife is able to take responsibility for a woman experiencing normal pregnancy and birth independently. In the case of abnormalities, she contacts the gynaecologist, who then takes over responsibility.

The profession of midwifery was first protected in 1818 and was revised in 1991.

6.1.2 History

Since the Second World War, there has been an important shift in midwifery care. The physiological delivery has moved from primary care to secondary care. The reason for this shift was the introduction of the compulsory health- and disablement insurance scheme in 1944, which specified that, from 1945 onwards, all deliveries in hospital and all specialist medical care would be reimbursed by health insurance, regardless of it having been a physiological or pathological birth. This decision was



prompted by an increasing number of gynaecologists and a surplus of hospital beds (Gooris 1994).

The midwives' course also became more and more focused on the midwife working in a clinical setting: the midwife who assists the gynaecologist during the delivery. In 1957, the midwives' course was categorised as nursing education.

In the last 40 years, the number of midwives in midwifery care has been reduced from 31% to 3%. Also the number of general practitioners active in midwifery decreased from 53% to 8.5% in 1991. On the other hand, the number of gynaecologists exploded from 15% (1950) to 86% in 1980 (ibid.).

6.2 The midwifery system

When a woman thinks she is pregnant, she can go to a midwife, general practitioner or gynaecologist. Usually a woman will choose a gynaecologist to be her primary care provider; it is exceptional to choose a midwife. Independent midwives and general practitioners have very limited access to hospitals. Some hospitals are 'closed' and therefore only accessible to doctors who have contracts with the hospitals. Other hospitals are 'open', which means that general practitioners have access to them. Independent midwives are rarely accepted for conducting deliveries in hospitals (Gooris 1994).

Midwives conduct 2-3% of all deliveries.

6.2.1 View on pregnancy and birth

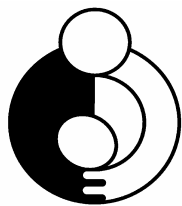
In spite of the facts that most women choose the gynaecologist to be their primary care provider and midwives rarely have access to hospitals, society and midwives both feel that pregnancy and birth are natural processes.

6.2.2 Division of tasks

Midwives are hardly involved in antenatal care, because most women go to a gynaecologist during their pregnancy. In the natal phase, midwives often play an 'assisting' role. But if a doctor is absent, the midwife is able to conduct the delivery on her own.

Midwives provide postnatal care in hospital under the supervision of the doctor on duty (Gooris 1994). In 2000, 815 deliveries were registered as conducted by independent midwives and reimbursed by national health insurance companies.

In 1991, total share of general practitioners active in midwifery care was 8.5%, but the share in antenatal care is higher. This is because some general practitioners guide



the women through the pregnancy, but leave the delivery to the gynaecologist at the hospital (ibid.). General practitioners conducted 1987 deliveries in 2000; gynaecologists conducted 107,180 deliveries.

6.2.3 Place of birth

Parents can choose where to give birth. They can give birth at home or at the hospital where their gynaecologist practises. Annually, only 600 deliveries take place at home (1%). The remainder takes place in hospital.

6.3 Number of professionals

In this paragraph, the number of midwives, gynaecologists and general practitioners active in midwifery will be discussed.

6.3.1 Midwives

In Belgium, there were 4,351 midwives practising midwifery in 1999. About 3% of those midwives work in independent free practices. The remainder is employed in hospitals in the public sector.

6.3.2 Gynaecologists

The number of gynaecologists for 1999 was estimated at approximately 450.

6.3.3 General practitioners

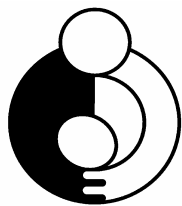
The number of general practitioners active in midwifery is not known.

6.4 Finance and income

6.4.1 General insurance system

Virtually, the whole population of Belgium is insured against sickness and disablement, under a publicly organised and controlled but privately managed compulsory health insurance system.

Health care is financed through a combination of social security contributions (54.4%), governmental subsidies generated by tax revenues (32%) and individual co-payments (13.5%). The social security contributions are paid by employees as a percentage of their salaries and by employers. Since January 1995, some groups (e.g. widows, orphans etc) have been partly exempted from contributing and the state pays on their behalf. Therefore, social security is partly financed through general taxation (Van Kemenade 1997).



There are two health insurance schemes:

- A general scheme which covers both major and minor risks and applies to employees and civil servants, the retired, handicapped and their dependants, making up 85% of the population;
- A scheme for the self-employed, which covers only major risks and accounts for most of the remaining 15% of the population. About 70% of the population of the self-employed take out additional insurance for minor risks.

All persons are required to subscribe to a health insurance company (sickness fund). There are 129 different sickness funds, which may provide additional insurance on request. A growing number of people purchase extra private insurance to cover additional costs or services not generally provided under the system of compulsory health insurance (ibid.).

Since January 1995, health insurance companies (sickness funds) have become more financially independent due to the introduction of a risk-adjusted system. The health insurance companies (sickness funds) are now (partly) responsible for their own deficits.

6.4.2 Reimbursement

The benefits of the statutory scheme include both health insurance cover and income support in the event of illness. The benefit packages vary according to employment status. Social health insurance has both forms of payments: restitution and benefit in kind.

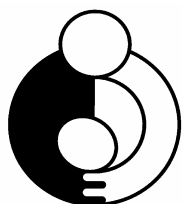
The insured may voluntarily change to another health insurance company (sickness benefit), but as premiums are identical there is little point. There has been a growth in private health insurance (supplementary insurance) as a result of the financial strains suffered by compulsory health insurance (Van Kemenade 1997).

Care provided by midwives and gynaecologists is reimbursed.

6.4.3 Income

Midwives are either paid a salary if employed or paid a fee-for-service if independent. If midwives are employed at the hospital, they receive a fixed salary. According to the National Council for Midwives, the starting salary for midwives in hospitals is €21,000. Midwives get extra allowances for night shifts, weekend shifts etc.

If midwives work independently, they receive a fee-for-service; this fee is dependent on the number of women she cares for. To get some idea about these fees, which are paid per service by social security insurance, some examples are shown below:



Activity	Fee
Delivery at home (labour not included)	€ 156.50
Conducting labour	€ 156.50
Prenatal care 1st session (intake)	€ 28.50
Prenatal care, next sessions	€ 20.50
Postnatal care (average per day)	€ 45.00

6.5 Training

6.5.1 Admission requirements

To be admitted to the course, the students must have finished secondary school. The diploma they get, must be equivalent to that required to enter university.

6.5.2 Colleges

The training of midwives is divided into two separate systems.

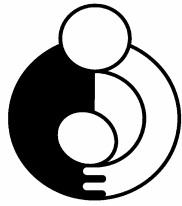
- The Flemish version of three years, with direct entry to the course.
- The Walloon version of four years. In the Walloon version, the students spend one year on nursing, one year on nursing/midwifery and only two years on midwifery.

In Walloon 11 and in Flanders 12, midwifery educational institutes provide midwifery education and training within High Schools, which will very soon be attached to universities.

In Flanders, the students have to complete 1,025 hours of theoretical education and 1,575 hours of practical training. In the Walloon provinces, the students have to complete 1,185 hours of specific midwifery practical training.

The number of new students is hard to estimate, because the Walloon version of midwifery-training is considered to be part of nursing education.

Midwives estimate the number of new students to be 500 and the total number of students to be 750. There are a lot of new students, but more than 50% of students drop out during the second year of their course.



6.6 Developments

6.6.1 Threats

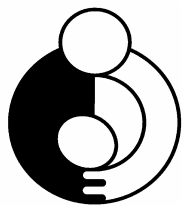
Midwives already conduct very few deliveries. And the fact that independent midwives have very limited access to hospitals and most deliveries are in hospital justify this situation. Furthermore, specialist medical care is reimbursed, independent of a pregnancy or if the delivery is physiological or pathological. That is probably why most women choose the gynaecologist to be their primary care provider. Also, general practitioners play a larger role in midwifery care than midwives do.

6.6.2 Opportunities

In Dutch-speaking Belgium, midwives are thinking of increasing their training to four years, including a module that would enable midwives to practice as independent midwives. According to the agreement of Bologna, a fourth year that would lead to the title of Master is being researched.

Both the Flemish and Walloon midwives are thinking of making ongoing training compulsory, to develop a dynamic and competent approach to the profession. The National Council of Midwives, which represents midwives nationally, is working on several projects. One of these projects is to give independent midwives access to hospital delivery wards.

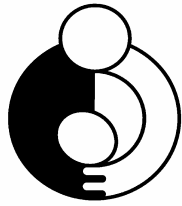
Some agreements with health insurance companies have also been made. Midwives now get an extra payment for work during holidays and weekends, and a second midwife now receives a higher payment for home births. Due to the recognition of their role and the reimbursements now being more realistic, more and more midwives are beginning to practice as independent midwives.



6.7 Statistics

Year	1999	2000
Inhabitants		10,100,000
Birth-rate	114,276	
Born alive	99.30%	
Stillborn	0.70%	
Perinatal mortality rate	0.73%	
Midwives	4,351	
Births per midwife		815
Gynaecologists	450	
General practitioners active in midwifery care		

The perinatal mortality is the number of stillborn and deaths weighing more than 500 grams until the 29th day after birth.



7. Midwifery in Denmark

7.1 The midwife

7.1.1 Tasks and responsibilities

The midwife helps the woman to deliver her baby and also provides antenatal and postnatal care. The Danish term 'jordemoder' (midwife) means, 'authorised health personnel' and has been protected by law since 1978.

In short, the activities midwives perform, are:

1. To teach antenatal classes and perform antenatal examinations. (On average, midwives do five examinations per woman, but this could be more if the woman has special needs)
2. To take responsibility for delivering all normal and spontaneous deliveries
3. To visit the woman in case of abnormalities
4. To provide postnatal care during the first few hours after the delivery
5. To be involved in the training course and up to 50 midwives are involved in research.

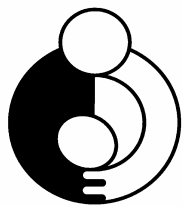
Midwives are able to take responsibility for a normal pregnancy and birth independently. In the case of an abnormal pregnancy and birth, the gynaecologist takes over responsibility.

In 6 out of 15 different hospital authorities, midwives are employed independently, under the county-chief midwife. In these counties, midwives work with more responsibilities in the primary sector.

7.1.2 History

After the Second World War, the government introduced regulations for better pregnancy and childbirth results. This boosted the profession of midwives considerably.

Until 1947 midwives had been private practitioners or county employees earning a small salary and fee per delivery (if the woman could pay that). Since the war, the fees have been paid by health insurance.



During the 1960s, women increasingly preferred to give birth in hospital or in a clinic. During those years there was a scarcity of midwives, resulting in nurses moving into maternity care in spite of having had different training.

In the 1970s and 1980s, doctors and midwives were influenced by the great leaps in technological power and 'consumer' viewpoints, which led to the present situation.

Midwives are now competent enough to work independently, but are often curtailed in their performance, due to their inferiority in employment. In most cases they work under the chief-obstetrician.

7.2 The midwifery system

When a woman thinks she is pregnant, she has three options of whom to turn to. First, she can go to a general practitioner. Secondly, she can turn to a midwife (at a midwifery care centre) and thirdly, she can go to a gynaecologist. If the parents do not go directly to the midwife and it is a normal pregnancy, the general practitioner or gynaecologist will refer the woman to the midwife. If there are any problems with the pregnancy, the midwife and general practitioner will refer the woman to the gynaecologist.

Midwives conduct approximately 70-75% of all deliveries; gynaecologists assisted by midwives conduct the remainder.

7.2.1 View on pregnancy and birth

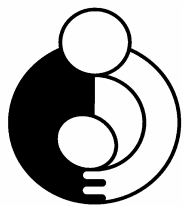
The prevailing view that pregnancy and birth are natural processes is unified in the Danish midwifery system. With normal pregnancy and birth, the woman is referred to the midwife.

7.2.2 Division of tasks

3,500 General Practitioners diagnose pregnancy. They also perform two antenatal consultations. Most of them provide antenatal and postnatal examinations. If it is expected that the pregnancy and delivery will be normal, the pregnant woman will be under the responsibility of the midwife. In the case of abnormalities, the gynaecologist will take over responsibility. Then the gynaecologist will conduct the delivery, usually in co-operation with midwives. Midwives also conduct home births. They visit the mother twice at home after the delivery.

7.2.3 Place of birth

Parents can choose where to give birth. In the case of a normal pregnancy, the delivery can take place at home, in a maternity clinic or in hospital. A maternity clinic



is a midwife-led unit that is part of the hospital. In the case of an abnormal pregnancy, the delivery takes place in hospital.

Just 1% of all births takes place at home. 99% Takes place in hospital and at the maternity clinics. Approximately 10% of these take place at the maternity clinic.

7.3 Number of professionals

In this paragraph the number of midwives, gynaecologists and general practitioners are discussed.

7.3.1 Midwives

Of the 1,600 registered midwives in Denmark, 1,350 are practising midwifery in 2001. Most midwives are between the ages of 43 and 44 years old.

Less than 1% of the midwives works in independent practices. Over 99% of the midwives work in the public sector (hospitals and maternity clinics). Midwives do not work in the private sector, because no deliveries are performed there.

7.3.2 Gynaecologists

In 2001 there are 880 gynaecologists.

7.3.3 General practitioners

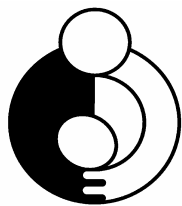
There are about 3,500 general practitioners that are active in midwifery care.

7.4 Finance and income

7.4.1 General insurance system

Health care in Denmark is generally considered to be a public responsibility. Virtually all health care services are financed, planned and operated by public authorities. The finances are derived mainly from general taxation. All residents in Denmark have equal access, free of charge, to most health care services, regardless of employment and financial and social status (Van Kemenade 1997).

The country is subdivided into 16 provinces (regional authorities), each containing 200 to 600 thousand inhabitants (with two exceptions). The 16 provinces are general administrative entities at regional level and are responsible for hospital care, primary care, curative care (except for home nursing) as well as for health promotion initiatives (ibid.).



82% of healthcare is financed through general taxation at a national, regional and local level. The remaining 18% is financed through co-payments by patients (of which 92% are direct payments and 8% are premiums for private insurance).

Basic health care services are provided free of charge to all citizens by the public health care sector and include both hospital and primary health care services. About 27% of the population are members of a private health care insurance company called 'Danmark'. 'Danmark' subsidises the costs of dental services and drugs (ibid.).

7.4.2 Benefit packages

In the Danish health care system, citizens may opt for one of two packages. About 96.4% (1991) opted for 'Group 1' membership, with a free choice of a family physician or general practitioner within the area. The patient's first contact with primary health care is the family physician. The family physician acts within the system as gatekeeper. The 'Group 2' package is not completely publicly financed. Patients have an unlimited choice of family physicians and open access to specialist care, but make a contribution from their own resources, usually in the range of 25% of the full amount (Van Kemenade 1997).

All midwifery care is provided free of charge. There is no (supplementary) private insurance for midwifery care. Midwifery care in the benefit package consists of five preventive medical visits, hospital admittance, medical assistance during the delivery in hospital or at home and abortion and sterilisation (Dialoog met de Burgers 2001).

7.4.3 Income

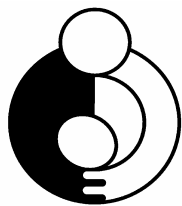
Midwives are either paid a salary if employed or paid by the client if independent. But there are very few private practices. The salaries of the public sector are regulated according to the developments in salaries of professional groups in the private sector. So, when the salaries of, for example, policemen rise, the salaries of midwives will also rise.

The average income annually for a midwife is about €32,000 to 35,000. This is exclusive of extra payments for overtime, late nights etc.

7.5 Training

7.5.1 Admission requirements

In order to be admitted to the midwifery-training course, students need to possess a student's degree (12 years of school) or an equivalent. Students also need to have at least nine months of relevant work experience (e.g. in old people's homes).



Every year, 900 students wish to be admitted, but only 90 can be admitted. 50% of the students are accepted on the basis of the highest degrees and 50% are accepted at random.

7.5.2 Colleges

The midwifery course takes 3.5 years.

The student must qualify in the following subjects:

- To promote good health
- To take care of the woman and family
- To provide professional midwifery care
- To prescribe and apply medication
- To document their own practice and evaluate their work in co-operation with women and colleagues.

The course does not have an academic level; it has a middle range academic level, which is roughly equivalent to a 'bachelor' level. The students who started in 2001 will be the first to finish their course with a bachelor's degree.

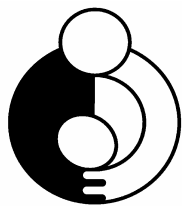
7.6 Developments

7.6.1 Threats

The prevailing view among midwives and also in society is that pregnancy and birth are natural processes. But discussions threatening the normal processes of parenthood are becoming very pressing.

The National Health Board has sanctioned a new system for the organisation of health care. The last six counties with midwives working in the primary care sector (see 7.1.1) may have to change their employment status to one of inferiority working under the guidance of a specialist like the normal practice in the larger hospital units. This may turn out to be a setback to midwifery in Denmark. It is threatening to envisage the midwife as the central figure in the normal process.

Families do not have the choice of continuous care during the pregnancy, birth and postnatal care unless they pay privately for one of the few private midwives.



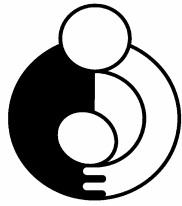
7.6.2 Opportunities

Nowadays, there is just one maternity clinic, apart from the obstetric ward. In order to strengthen the midwife's position, it would be good if there were more of these independent maternity clinics led by midwives.

7.7 Statistics

Year	1998	2000
Inhabitants		5,200,000
Birth-rate	64,792	
Born alive		
Stillborn		
Perinatal mortality rate	0.80%	
Midwives	1,300	1,350 (1,600 registered)
Births per midwife		
Gynaecologists		880
General practitioners active in midwifery care		3,500

The perinatal mortality is the number of stillborn and deaths from week 28 of the pregnancy until the first week of life.



8. Midwifery in Finland

8.1 The midwife

8.1.1 Tasks and responsibilities

A Finnish midwife is a trained and registered health care professional, who provides ante- and postnatal care in maternity clinics (primary health). In hospitals she provides antenatal, natal and postnatal care. She is active in the whole field of reproductive health, including gynaecological nursing and family planning.

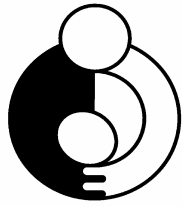
In short, midwives' activities consist of:

1. Antenatal classes
2. Antenatal check-ups
3. Normal delivery (incl. episiotomy and suture)
4. Assistance in case of abnormalities
5. Postnatal (home) visits
6. Parental education (e.g. breastfeeding, parenting skills).

In primary care, the midwife or public health nurse (PHN) performs 16.6 antenatal check-ups per pregnancy independently. After that, she refers the woman to a general practitioner or a gynaecologist in an antenatal clinic. The midwife also provides antenatal classes and birth preparation. Because births are only performed in hospital, midwives in primary care do not conduct them. In the postnatal phase, the midwife (or PHN) pays one or two home visits to check the mother and baby. After that, the baby is transferred to the care of the public health nurse. The mother remains under the supervision of the maternity clinic until eight weeks after the birth.

In secondary care, the midwife assists the medical specialists in the antenatal clinics, and runs special clinics for, amongst others, diabetics and drug addicts. She also does ultra-sounds (screenings) and all midwifery and nursing duties on the antenatal wards.

Natal care is always provided in a hospital, where the midwife conducts normal births. She is allowed to administer non-narcotic pain relief, episiotomies and suture. If there are abnormalities, the midwife assists the gynaecologist; she provides care under his direct medical supervision.



During the postnatal phase, the hospital-midwife is in charge of the care and wellbeing of mother and baby. She provides support with breastfeeding and teaching parental skills.

The law has protected the profession of midwives since 1711, but not their functions and activities.

8.1.2 History

Midwifery has a long history in Finland. The first midwifery regulations were formed in 1711 in united Sweden-Finland. In 1777 a new midwifery directive stated that every parish should have at least one trained midwife.

A new era in Finnish midwifery care started when a maternity hospital and midwifery school were set up in 1816. At the end of the 19th century there were approximately 600 midwives, although just ¼ of the women used their services.

At the turn of the century, the Journal of Finnish Midwives was first published and within a few years there was a midwifery association in almost every county. Finland became an independent republic in 1917.

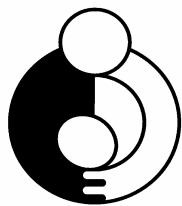
The young nation had to make up its own law and regulations. A law on midwifery and delivery hospitals was introduced in 1920, forbidding everybody but a trained midwife to conduct deliveries. It also regulated the salary and supervision by a general practitioner. Most births took place at home.

In 1944, 41% of the births took place at home. Since then, the law has protected the organised maternity care and midwifery care. Every woman had the right to use these services, regardless of her economical status. Midwives were trained to work both in the community and in hospitals.

Around 1950, a central and district hospital system was developed. Hospitals took care of 75% of the births now. This gave the municipal midwives more time for maternity care and birth preparation/education.

In the 60s, home births became rare (3%). Medical authorities specified that public health nurses could provide all primary health from then onwards. A special training course added on to the nursing course satisfied the demand for hospital-nurses.

A new national health law from 1972 onwards has been the basis of the present existing system. The law did not even mention midwives and maternity care. Public health nurses were supposed to provide for primary health needs, and the hospital-midwives were replaced by 'specialised nurses'. At the same time the use of technology increased and home births were abolished.



At the beginning of the 80s, however, the Federation of Finnish Midwives *did* accomplish the foundation of a new course. Newly-trained midwives could now work in primary as well as in secondary care.

Finland became a full member of the EU in 1995. This led to several adaptations of midwifery practice. Now, midwives are highly appreciated.

In the past, the training course consisted of 15 months vocational hospital training. In 1930, the course moved from University settings to the Midwifery Institute. It was extended to two years and maternity care was included in the curriculum. Later the curriculum was amended with subjects like gynaecology, birth preparation and mental health. Midwives were trained to work in both the community and in hospital. Their education changed radically in 1968. It became a 9-month special training course in maternity care and gynaecological nursing, based on a general nursing exam. It was only in use until the 1980s, when the Finnish Federation of Midwives managed to establish a midwifery course again. Since then, students have been able to qualify as midwives. They are capable of working in primary and secondary care.

8.2 The midwifery system

A lot of professional groups are active in midwifery care: midwives, gynaecologists, general practitioners, paediatricians and public health nurses (PHN).

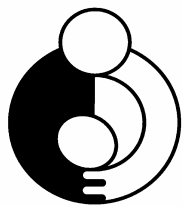
8.2.1 View on pregnancy and birth

The prevailing view of pregnancy and birth in Finland is that these are natural processes. Still, there is a trend towards 'overmedicalisation' because society prefers the use of technical back-up. This view can be seen in some aspects of the Finnish midwifery system.

8.2.2 Division of tasks

A midwife in Finland is responsible for the care she provides. But the final responsibility over all phases of (ab)normal pregnancy and birth lies with the gynaecologist, the paediatrician and the general practitioner; the general practitioner being partly responsible for ante- and postnatal care and the paediatrician being jointly responsible only for postnatal check-ups.

Midwives conducted 78% of all deliveries in the year 2000, under the medical supervision of a gynaecologist. The rest of the deliveries were conducted by the gynaecologists themselves. This 22% assisted births such as breech positions and vacuum extractions.



When a woman thinks she is pregnant, she books in at a maternity clinic at the health centre. She automatically comes under the care of a midwife or a PHN. The PHN is also largely involved in postnatal care for the baby.

The midwife, the PHN or the general practitioner from the health centre refers the woman to the hospital (ANC) when she is going to deliver, or in case there is a medical problem.

8.2.3 Place of birth

There is no other option than to give birth in a hospital. The only deliveries at home in 2000 were on special request from the parents with a private midwife or by accident. This concerned ten births in total.

8.3 Number of professionals

In this paragraph, the number of professionals active in midwifery care will be discussed.

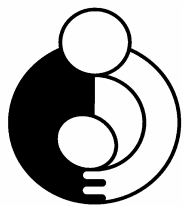
8.3.1 Midwives

Of the 4,220 registered midwives in Finland, approximately 2,000 practise midwifery. However, it is difficult to estimate this number as midwives can also be called Nurses, Charge nurses or PHNs and recorded in the statistics as such. There are about 1.63 midwives available per 1,000 fertile women. Only 25 of the registered midwives are male. Most midwives are between 30 and 50 years old.

Age	Midwives (%)
<30 years	12%
31-40 years	35%
41-50 years	30%
>51 years	23%

Table 8.1: Age structure Finnish midwives

Most midwives (99.9%) are employed in the public sector. This sector consists of the hospitals and the maternity clinics at the community health centres. The Finnish Federation of Midwives estimates that 1% of these midwives work independently in their leisure time too. There is a small group of midwives (approximately 1%) working in the private sector. The percentages are difficult to estimate, as there are no records being kept.



8.3.2 Gynaecologists

There are about 584 gynaecologists in Finland.

8.3.3 Others

Some of the 1,950 general practitioners work 3.5 hours per week in antenatal and postnatal care.

There were 13,138 primary health nurses working in Finland in the year 2000 (National Research and Development Centre 2001).

8.4 Financing and income

8.4.1 Finance system

In Finland, municipalities are mainly responsible for arranging basic services such as schooling, social and health services for the local population. Currently, there are 452 municipalities. The main decision-making power lies within the municipal council. Decisions concerning planning and organisation of health care are made by the Health Board, the municipal council, the municipal government and the leading personnel of the municipal health centres (Van Kemenade 1997).

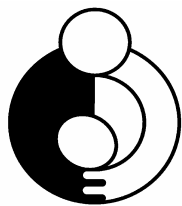
The country is divided into 21 hospital districts, which are responsible for providing hospital services and co-ordinating public hospital care within their area. Each municipality located in the district area must be a member of the hospital district (ibid.).

The Ministry of Social Affairs and Health directs and manages social and health services at a national level. It defines general policy lines, prepares major reforms and directs and monitors their implementation and assists the government in decision-making. A Basic Security Council is attached to the Ministry and may investigate any deficiencies observed in the provision of municipal health services (ibid.).

The government makes the state's annual budget proposal and the Parliament makes the final decision on the amount of money to be allocated to the health care sector.

The municipalities are pretty free to decide on administration, personnel and user charges. They have the right to purchase services from any provider of their choice and to contract out services from the private sector (ibid.).

Within the health care system, there is a statutory state health insurance scheme. The Social Insurance Institute runs this scheme with about 400 local offices throughout the country. The insurance is used to provide part reimbursement for prescribed



medication, transportation costs, private medical care, occupational health care, student health care and rehabilitation.

Everyone in Finland has the right to health services, regardless of ability to pay or place of residence. Health care in Finland is mainly tax-financed. Both the state and municipalities have the right to levy taxes. The municipalities also receive a subsidy from the state for health care, social services and schooling. The subsidy is calculated according to demographic criteria and is automatically paid in advance (Van Kemenade 1997).

National state health insurance revenues come from insurers and employers, returns on assets held and state contributions. The contribution is a specified percentage of income. The state pays total costs of sickness, parenthood and special care allowances (ibid.).

Finland has a limited private insurance sector (2% of total health care expenses) in addition to a public health care scheme.

8.4.2 Benefit package and co-payments

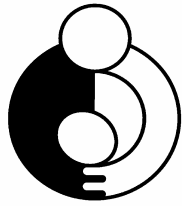
Municipalities can decide whether or not to charge for services and can also set the rate of charges (up to a maximum). However, according to the law, some services must still be free of user charges.

The care provided at the maternity clinics (under the responsibility of the municipals) are free of user charges and funded by taxes. Hospital care, including visits to the antenatal clinics, has a subsidised user charge. The hospital charges the municipal for the remaining amount. The government sets a maximum price for the user charges.

Every baby (mother) has the right to a benefit package consisting of supplies (clothing, nappies, booklets, etc.). If the mother does not want the package, she can get some money instead. In order to get this benefit funded by the Social Insurance Institute, she has to attend a maternity clinic.

8.4.3 Income

Midwives are paid a salary for employment, are employed by hospitals or by maternity clinics. The salaries are fixed in a general salary agreement made by the trade unions. The Federation of Finnish Midwives estimates the annual average income of a Finnish midwife to be at €26,910.



8.5 Training

8.5.1 Admission requirements

Midwifery-training is a 1½ -year training course complementary to the 3-year nursing course.

In order to be admitted to the nursing course students must do a matriculation, or have a secondary school or college diploma in the same field. Students should also be in good health. They must pass an aptitude test before enrolment.

8.5.2 Colleges

Students qualify as midwives. They are capable of working in primary and secondary care.

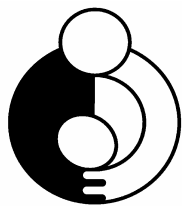
The 200 midwifery students must earn 180 credits in order to get a degree. The practical training is worth 39 credits in total, of which 19 concern natal care. The subjects that are dealt with are:

- Basic midwifery studies
- Professional studies in nursing
- Professional studies in midwifery
- The midwife and the development of the profession
- Optional studies.

The Ministry of Education is responsible for the training, together with the schools themselves.

8.6 Developments

The purpose of the Finnish Federation of Midwives is to be a unifying organisation for trained midwives and midwifery students. The goals are to promote sexual and reproductive health, to support the development of midwifery care and to promote the development of midwifery skills. To do this, the Federation takes the initiative to provide and support education, research, make publications and contacts with (inter)national organisations. In the current situation, the Federation is facing some threats, but there are also some opportunities to be grasped.



8.6.1 Threats

There is a trend towards increasing 'medicalisation'. Young people seem to think that technical back-up is necessary. This is reflected by the increased use of epidural anaesthesia and Caesarean section, for example.

It is hard to develop midwifery skills and to promote the midwives as professionals, when the primary health nurse (PHN) performs a lot of midwifery activities. The PHN provides antenatal care and she is also largely involved in postnatal care for the baby. Despite the protests of midwives, the trend with the PHN providing primary maternity care is developing rapidly.

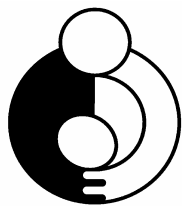
The municipalities can choose to employ a midwife or a PHN. A study done in 1998 (4/1998) shows that 60% of the maternity clinics did not employ a midwife. The prevailing view in primary health care is that a PHN is the 'Family nurse', taking care of the whole family from baby to grandmother, pregnancy and birth included.

It should be noticed however that a 'maternity clinic' usually encompasses only one visit to the PHN. In the municipals that have chosen to maintain the maternity clinics, there is a midwife, a PHN or a 'doubly competent' person. It is difficult to estimate the number of midwives providing antenatal care in primary health, as their positions are called PHNs.

Apart from these threats, it is difficult to choose a midwife unless the woman goes private. And private services are not free. Only in the areas of economic growth is the demand for private services increasing. This leaves the Finnish women living in less favoured areas often without midwifery services.

8.6.2 Opportunities

The midwives are highly appreciated today. In a recent survey, midwives were number nine on the ranking list. If midwives continue the publication of research results and information on good midwifery care and on the choices parents have, the public will support them in their goals. Most pregnant women use free antenatal care services. Now the aim is to get them to purchase this care from a midwife. So midwives will not only conduct deliveries, but also become the primary midwifery care providers.



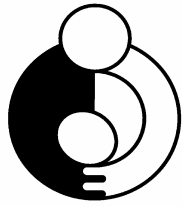
8.7 Statistics

Year	1998	1999	2000
Inhabitants			5,100,000
Births	57,345		
Born alive	57,108 (99.6%)*		56,730
Still born	237 (0.4%)*		
Perinatal mortality rate	0.49%*	0.56%	0.63%
Midwives		(4,208 registered)**	2,000 (4,220 registered)
Births per midwife			28
Gynaecologists		540**	584
General practitioners active in midwifery care			1,950

Definition of perinatal mortality: Perinatal mortality is defined as the proportion of stillborn and liveborn infants dying during their first week of life (<168 hours) per 1000 births. A stillborn is defined as a newborn, who does not have any signs of life and who has a weight of 500 grams or more, or who's gestation period is 22 weeks or more.

*Statistics Finland Library

** STAKES: the National Research and Development Centre for Welfare and Health/ Library



9. Midwifery in France

9.1 The midwife

9.1.1 Tasks and responsibilities

The profession of midwives in France consists of pregnancy diagnosis, antenatal care, birth and postnatal care for mother and children. Midwives are competent enough to supervise the growth and development of children until they are three years old. The profession also consists of family planning consultations. As well as supervising pregnancy and conducting normal childbirth, midwives educate and counsel future parents.

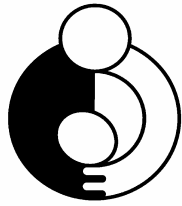
In short, the tasks of the French midwife include:

1. Pregnancy diagnosis and all antenatal care
2. Antenatal classes
3. Echography (when necessary)
4. Medical supervision of normal labour and birth (incl. episiotomy, suture, infusion, resuscitation, etc.)
5. Postnatal medical supervision of mother and child (incl. examinations as Guthrie-test, bloodtest)
6. Parental education (e.g. breastfeeding, incontinence, nutrition) and family planning.

As mentioned above, a midwife is able to take responsibility for a normal pregnancy and birth independently. The law says, “in the case of a pathological birth and postpartum, the midwife must call the doctor”. Therefore, the midwife sends the woman to the gynaecologist for a consultation if any abnormalities during pregnancy occur. He will decide whether the midwife can continue her tasks or whether the patient needs a prescription for more examinations by a midwife. The gynaecologist attends the delivery with the assistance of the midwife in case of complications during birth.

However, because the law does not prescribe what is normal or abnormal, every hospital has its own protocol written by doctors.

Some midwives have started independent free practices to provide mostly antenatal and postnatal care. Only some of them perform deliveries (at home and in maternity



units). They have to follow 'good practice' regulations, also decided upon by experienced doctors.

Midwives in France have to be more and more able to operate all kinds of medical instruments, of which they should be able to read and interpret data. Often, the treatment of women during pregnancy and birth has become limited to constant check-ups of the maternal blood pressure, the heartbeat of the child and the contractions, which are stimulated by oxytocin, and the epidural analgesia.

The midwifery functions and activities are protected in the Public Health Code and the Public Function Status. It states that midwives are free in their own practice. The law also describes a list of instruments, midwives can use, and a list of medicaments and labour tests they can prescribe. The midwife will consult a doctor if she decides the patient needs one of these methods.

Midwives in France participate in 99.5% of all births.

9.1.2 History

The profession of midwives has been protected by law since 1846 by the Public Health Code, and the Ethical Code of 1944.

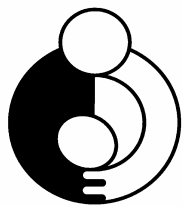
Just after 1945, midwives believed that their working load would be less if they worked under doctors' orders. Private maternity clinics have been mistaking the responsibilities of midwives ever since. The independence of midwives and responsibility for their own actions was not confirmed by law until 1995.

Over the years, the job responsibilities of midwives in France have become more and more 'technicalised' due to major technological discoveries. A lot of therapeutic and diagnostic progresses have been made in medical science. The ultra sound scan and the electronical surveillance of birth have been used in French midwifery care ever since.

Although midwives in France have gained competencies and technological skills, they have lost part of their independence since 1970. In order to guarantee and improve the safety of pregnancy and birth, new standards and procedures have been made. As a result of this, pregnancy and birth have become multidisciplinary issues. This will be discussed more thoroughly in paragraph 2.

9.2 The midwifery system

Midwifery care in France is multidisciplinary. Paediatricians, anaesthetists, psychologists, obstetrician-gynaecologists and midwives all work together in a team.



Radiologists and geneticists are active in midwifery care too. And general practitioners are also allowed to practice midwifery.

Of all births, 70 to 75% took place under the responsibility of a midwife in the year 2000. Gynaecologists were accountable for 25 to 30% of all deliveries.

9.2.1 View on pregnancy and birth

In France they say: “You only know two hours after the birth that the pregnancy and birth were normal”. Only a few midwives believe that pregnancy and birth are natural processes in life to start with, until they diagnose it. However, the prevailing (potentially pathological) view is expressed in the features of the French midwifery system most of the time.

9.2.2 Division of tasks

Women see gynaecologists as well as midwives and general practitioners for different 'aspects' of their pregnancies (Devries et al. 2001). It is recommended that preparation courses always contain one or more information sessions with an anaesthetist. But not every hospital does this, due to a lack of anaesthetists.

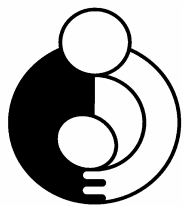
A midwife is allowed to perform normal births on her own, and a gynaecologist takes over if there are any complications. She then acts alongside the gynaecologist. Everybody is responsible for his or her own actions in the different phases of pregnancy and birth.

However, in the private sector (i.e. hospitals and maternity clinics) a gynaecologist should always conduct the delivery of the baby, in accordance with the contract he arranges with the parents. The midwife then conducts the birth until the gynaecologist arrives at the second stage of labour. Even though midwives in private settings usually act in obedience with the gynaecologists, they remain responsible for their own actions all the time.

According to the Ethical Code, the gynaecologist is never the hierarchical superior of the midwife and the gynaecologist can never free a midwife from her medical responsibility (not even when complications occur). Therefore, the position of midwives working in private organisations is often very uncertain.

9.2.3 Place of birth

Somewhere around 1945, 50% of all women delivered their baby at home under the guidance of a midwife. Since then a shift towards hospitals has taken place. Nowadays, almost all women deliver in the hospital, where their gynaecologists work. Although there are some differences within the country and between hospitals/clinics,



a large percentage of births take place in large hospitals (Devries et al. 2001). The number of home births has come down to less than 1%, of which half accidentally take place there. Midwives perform almost all home births (99.9%).

9.3 Number of professionals

In this paragraph the number of professionals in midwifery care will be discussed.

9.3.1 Midwives

Of the 16,687 registered midwives in France 15,027 practice midwifery (in the year 2000). Most of them (99.5%) are female. The average age of midwives is estimated at 43 years old (National Officer Board 2000). There is one midwife available per 1,000 births.

Of all midwives, 60% are employed in public hospitals and 25% in private hospitals. The rest (10-15%) work as independent midwives (National Officer Board 2000). Independent midwives mostly provide antenatal and postnatal care, and some of them do deliveries (at home and in maternity units). The number of independent midwives has been growing over the past five years.

9.3.2 Gynaecologists

In 2000, there were approximately 4,674 gynaecologists who were specialised in midwifery care (obstetricians) (Doctors National Board). In fact, this means there is a shortage of gynaecologists. Medical students find the profession unattractive because of the high pressure of work, stress and relatively bad payments.

At this point 27% of the gynaecologists are female. A growing number of the female obstetricians work part-time (Jongmans 1999).

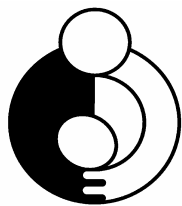
9.3.3 General practitioners

All general practitioners in France are allowed to be active in midwifery care, but there are no statistics about how many actually do it. The density of general practitioners in general varies between 118 and 309 GPs per 100,000 inhabitants (Doctors National Board).

9.4 Financing and income

9.4.1 Finance system

The health care system is under the regulatory authority of the French government, which directly intervenes in the production and financing of health care services. At a



national level the Ministry for Social Affairs and the Ministry of Health are the most important government 'actors' in the health care sector (Van Kemenade 1997).

The Regional Bureaux of Health and Social Affairs (DRASS) are responsible for the smooth running of all health care delivery services, prevention and local health promotion. Their main responsibility is to plan health and social amenities, through the imposition of an annual budget control or a revision of the 'health care map' which establishes the number of hospital beds and sets standards for the allocation of expensive equipment. Every region makes a health care map, within the regulations of the Ministry of Health. The maps are based on analyses of regional and local needs. The aims are control of the hospital sector, convergence of regional differences and gearing of the development of the private and public sectors (ibid.).

Almost the entire population (99%) is covered by the statutory health insurance scheme, which is a part of France's social security system.

The health insurance scheme is administered by social security sickness funds (Assurance Maladie de la Sécurité Sociale). The sickness funds are divided into a number of 'regimes', each of which represents a different sector of occupation. About 81% of the compulsorily insured French people are, for example, covered by the scheme for salaried employees.

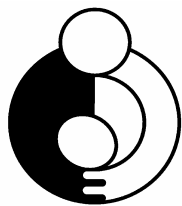
In addition to compulsory insurance, about two thirds of the population take out optional supplementary insurance.

The social security system is funded by compulsory contributions related to income and shared between employers (70%) and employees (30%). Direct payments from the government are limited to hospital investments and insurance for the handicapped and special groups of the unemployed.

A national central agency (URSAFF) gathers together all the contributions collected at a local level. Funds are then dispensed to local sickness funds. The regions negotiate with the sickness funds regarding tariffs for hospital-services and day-care in private clinics.

9.4.2 Reimbursement

Restitution by the social sickness fund varies according to the type of care. The sickness funds reimburse one hundred percent of the amount: all midwifery consultations, 3 ultra sounds in the case of a normal pregnancy (more after agreement), tests, 8 antenatal classes and all care from the 6th month of the pregnancy until the 7th day after the delivery (until the 21st day if pathological). Other kinds of care and postnatal care after the 7th day are partially reimbursed by the social insurers (70%) and completed by private insurers most of the time. Private insurers reimburse



costs above the conventional fee (i.e. extra and more luxurious care), depending on the contract with the insured.

9.4.3 Income

Midwives, who work in public hospitals, earn a salary, based on scales applicable to all public hospitals. In the private sector, the salary is nationally negotiated between trade unions, where midwives are not (or badly) represented, and representatives of the private clinics. The professional trade unions are not allowed to participate. But as there are not enough midwives acceding to work in private clinics, they can negotiate with the clinics directly.

Independent midwives get a fee for each service they provide. The government, the unions and social security determine the amount of this fee.

Midwives estimate their average annual income to be between €18,544 and €28,934. A midwife in the private sector is paid less than a midwife in the public sector.

9.5 Training

9.5.1 Admission requirements

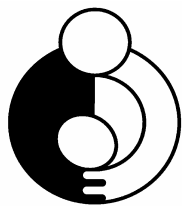
Before enrolment on a midwifery course, a student needs to do A-level examinations. This is a diploma (baccalauréat) from secondary school, which grants access to a university education. Students also have to succeed in a competitive examination. From next year onwards, instead of the competitive examination, a student has to fulfil the first year of medical university in order to be admitted.

9.5.2 Colleges

There are 33 schools for midwifery education, which accept 760 new students each year. It takes four years to become a midwife. In this period of time a student has to complete 1,820 hours of theoretical education and 4,370 hours of practical training. Students receive their diploma from the Faculty of Medicine when they graduate.

Examples of subjects that are dealt with are:

- Antenatal consulting
- Normal and abnormal birth
- Postnatal care
- Supervision of normal babies' growth and development



- Ultra sounds
- Anatomy
- Physiology
- Pharmacology
- Paediatrics
- Intensive care.

A student needs to perform at least 80 births, 10 episiotomies and sutures, 10 artificial deliveries, some newborn resuscitation and 2 breech deliveries. Furthermore, she has to provide antenatal care to a minimum of 100 women without pathology and to 60 women 'at risk'. The student is also trained in medical supervision.

All schools are under the guidance of a headmidwife, and a doctor is the director of the course. The schools are responsible for the organisation of the practical and theoretical course, of which the contents are constitutionalised by the government to guarantee the ability of midwives to care for women and newborn babies, when they finish the course. Public hospitals and university hospitals are obliged to participate in the training course.

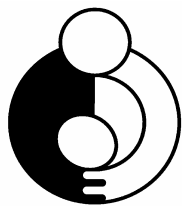
If students insist on following a part of their practical training in private maternity wards or with an independent midwife and if the college approves, the private sector is allowed to participate in the training too. For maternity wards, antenatal care and antenatal classes, this is usually possible only in the 4th year of the course; it is also possible to train in maternity wards and antenatal classes for 2 weeks in the 2nd and 3rd year.

9.6 Developments

There have been various developments in the current situation, which can result in an opportunity or threat to French midwifery as a medical, independent profession, active in antenatal consulting, normal birth and postnatal care.

9.6.1 Threats

As said in paragraph 2.1, pregnancy and birth are 'medicalised' processes in France. Even though the National Union for Midwives considers the current view on pregnancy and birth too technical, most of the midwives hold a pathological view. Together with the Union, only a few midwives feel the contrary and think these are natural processes in life. But it is the case that legal proceedings and court decisions



have led to an increasing usage of (new) techniques, just to make sure “everything has been done to prevent any complications”.

A point of criticism of the Union is that midwifery education is still a practical training course, given at maternity wards of university hospitals, where students are shown the abnormal pregnancies, births and postpartum. Therefore, some headmidwives of the midwifery schools agree that the natural aspects of pregnancy and birth are too often neglected.

According to the Union, another negative aspect is that any doctor can conduct midwifery care, even if he has not had any experience or training in a maternity ward or in obstetric consultation. The public does not know this.

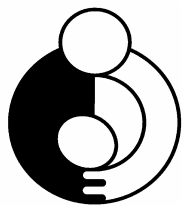
Midwives themselves express their concerns with regard to low salaries, the limited possibilities of providing antenatal care and the obligation to work according to protocols made by doctors. Moreover, independent midwives who *do* provide antenatal care are being kept out of the hospitals (Jongmans 2000).

9.6.2 Opportunities

As the number of gynaecologists is low and continuing to go down, midwives are trying to change the midwifery system and to strengthen their position in it. Midwives see opportunities to expand their job responsibilities, with regard to antenatal consulting, prescriptions of contraceptives and independent guidance of the whole process of normal pregnancy and birth. The National Union for Midwives is already trying to develop a better fee for consultations and birth; the UNSSF follows and supports the National Association of Independent Midwives that works to re-establish insurance for home births.

A few midwives and women feel dissatisfied about the French midwifery system. As an alternative to home birth and the 'medicalised' hospital birth, they are planning to set up birth centres where low risk women can deliver babies in a 'homelike' atmosphere with the personal guidance of a midwife (Jongmans 1999). This too can contribute to recognition (from doctors as well as from the public) of the fact that pregnancy and birth are normal and natural processes in life. And to the positioning of the French midwife as an independent practitioner of physiological midwifery.

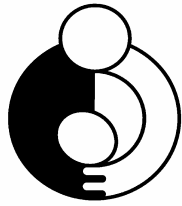
From next year onwards, midwives will be trained at medical university level. This will provide the midwives with the opportunities to conduct research in the field of midwifery to support their goals as described above.



9.7 Statistics

Year	1995	2000
Inhabitants		57,700,000
Births	736,487	
Born alive	731,332 (99.3%)	778,900
Still born	5,155 (0.7%)	
Perinatal mortality rate	0.76%	
Midwives		15,027
Births per midwife		
Gynaecologists		4,674
General practitioners active in midwifery care		

Definition of perinatal mortality: the number of stillborn and deaths from week 25 of pregnancy (or 500 grams), until the 7th day of life.



10. Midwifery in Germany

10.1 The midwife

10.1.1 Tasks and responsibilities

Since 1985, the Law has been protecting the profession of German midwives. According to this law, a midwife is trained and qualified to provide care and counseling to women during normal pregnancy, birth and post-partum.

A midwife is the only skilled person, other than a physician, in the health care profession who is legally entitled to deliver medical care independently (without a nurse or physician).

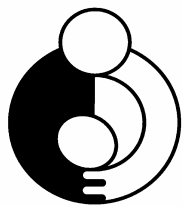
The law also requires that for every birth, both at home and in hospital, a midwife must be present. Physicians are required to call in a midwife for every delivery. However, a physician must be called in for any complications. When it comes to decision-making in cases of complicated labour, the physician assumes the final decision (Scheuermann 1995).

Areas in which midwives are entitled to provide professional services include the following:

1. Antenatal examination and monitoring
2. Antenatal classes and counselling
3. Treatment of disorders during pregnancy, such as diabetes mellitus, hypertension and anaemia (this may only be done after the midwife has informed the woman of the disorder and treatment options by a physician);
4. Normal deliveries, including episiotomies
5. Complete postnatal care for at least ten days, including nutritional counseling and a follow-up.

Ultrasound and laboratory examinations can only be done by a physician. Every woman has the option to choose between a physician and a midwife as her primary care provider.

Because of these limitations on midwifery, both midwives and physicians will see most women. This may lead to conflict, just like different opinions regarding management (ibid.).



In conclusion, the midwife and the physician share the final responsibility for normal pregnancies and births. And the physician is ultimately responsible if there are irregularities.

10.1.2 History

The midwifery law of 1938 required the presence of a midwife at every birth and fully recognised midwifery as an independent profession. In 1941 the first training course for midwives began. In 1963 new training and examination ordinance came into force. The most important law with regard to tasks and responsibilities described above was made in 1985.

Over the years, the profession of midwives has become increasingly dominated by doctors. In the 1980s, gynaecologists tried to persuade the government to forbid home births so that everybody had to deliver their baby in hospital. This scheme failed, because of the support of the World Health Organisation (WHO) to the German midwives (Treffers 2000).

But still, the promotion of midwifery interests frequently encounters resistance by gynaecologists. There is a long-standing conflict related to an overlap of skills and services that both professions claim as their own (Scheuermann 1995).

10.2 The midwifery system

Both midwives and gynaecologists are important in the German midwifery system. As has been stated, every woman is free to choose her primary provider for routine examinations during and after pregnancy. But until now, it is still common for women to go to a gynaecologist first. In the natal and postnatal phase, paediatricians are also active.

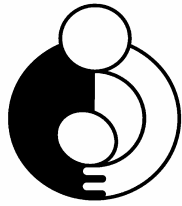
It is not clear how many of the 770,774 births in 1999 were conducted by midwives or by gynaecologists.

10.2.1 View on pregnancy and birth

The German midwifery system complies with the general view on pregnancy and birth. Both midwives and society consider these events as natural processes and midwives are required at every birth.

10.2.2 Division of tasks

For all deliveries done in hospitals, gynaecologists are present, even when the midwife is on duty. In the case of a difficult labour, the gynaecologist is ultimately responsible. Midwives and gynaecologists have overlapping competencies.



Consequently, they may compete for patients. Sometimes gynaecologists will not accept, or only with resistance, a woman for ultrasound examinations or treatment of pathological conditions if she plans to return to her midwife for appropriate care. Arguments about midwives' duties and competencies are frequent (Scheuermann 1995). As stated previously, gynaecologists work in the same area as midwives. In fact, they are more involved in antenatal care than midwives.

A midwife provides all aspects exceeding primary medical services.

10.2.3 Place of birth

Every woman can choose where to give birth. For normal deliveries, there are three possibilities (BDH 2000):

1. The clinical birth (delivery and early childbed in the hospital)
2. The ambulatory birth (delivery in clinic, birth centre or practice and childbed at home)
3. The home birth (delivery and childbed at home).

The number of home births decreased from 42.6% in 1960 to 0.8% in 1991. More than 98% of all deliveries are currently performed at hospitals. There were only 8,578 non-clinical births in 1999. Yet, more and more hospitals are trying to create a homely atmosphere.

10.3 Number of professionals

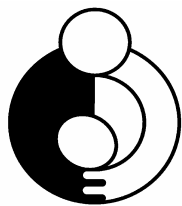
In this paragraph the number of midwives and gynaecologists will be discussed.

10.3.1 Midwives

There are approximately 15,000 midwives in Germany. Most of them work in hospitals.

Independent practices of midwives and birth centres are attracting more and more interest. In 1983, 23% of the midwives worked in independent practices, of which many had an additional part-time position in a hospital. Nowadays, 1/3 of the midwives are self-employed, 1/3 of the midwives are both self-employed and employed and 1/3 of the midwives are employed.

99% of all midwives are female.



10.3.2 Gynaecologists

There are more established gynaecologists than there are midwives (more than 15,000).

10.4 Financing and income

10.4.1 General insurance system

In 1883 the German health care system started with the introduction of a compulsory health insurance system. Germany is recognised as the first country to have introduced a national social security system, the Bismarck-model (European Observatory 2000).

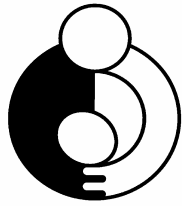
A fundamental facet of the German political system (and more specifically the health care system) is the sharing of decision-making powers between the states (Länder) and the federal government, with further powers governing statutory insurance schemes being delegated to non-governmental corporatist bodies (*ibid.*).

In 1999 there were 453 statutory sickness funds with about 72 million insured persons and 52 private health insurance companies covering about 7.1 million fully insured people.

Health insurance companies (sickness funds) can be divided into seven different groups. All authorities are non-profit making and are based on the principle of self-government, elected by membership. By law, sickness funds have the right and the obligation to raise contributions from their members, which includes the right to determine what contribution rate is necessary to cover expenditure. The Health Insurance Contribution Exoneration Act of 1996 interfered with this right by legally lowering the contribution rates of all sickness funds on 1 January 1997 by 0.4% (*ibid.*).

Contributions towards statutory health insurance with its current 453 sickness funds constitute the major system of health care financing in Germany. Becoming a member of a sickness fund is compulsory for employees whose gross income does not exceed a certain level and is voluntary for those above that level. Contributions are dependent on income and not on risk and are shared equally between the insured and their employers (*ibid.*).

Traditionally, the majority of insured people had no choice over their sickness fund and were assigned to the appropriate authority (fund) based on geographical and/or job characteristics. This mandatory distribution of fund members led to greatly varying contribution rates due to different income and risk profiles. The Health Care Structure Act gave almost every insured person the right to choose a sickness fund



freely (from 1996) and to change from one sickness fund to the other on a yearly basis. All general regional funds and all substitute funds were legally opened to everyone and they had to have a contract with all applicants (ibid.).

To provide all sickness funds with an equal starting point in a competitive field, a risk structure compensation scheme to equalise the difference in contribution rates and expenditure was introduced.

In the German statutory-based system, three other main sources of finance can be identified: taxes, out-of-pocket payments and private health insurance. Private health insurance will be discussed now (ibid.).

In the German system, private insurance has two facets: to fully cover a certain percentage of the population and to offer supplementary insurance to insured people. The 7.1 million with full-cover private health insurance consist of three main groups:

- people with an income above the sickness fund level
- self-employed people
- active and retired permanent public employees

Fully privately insured patients usually enjoy more benefits equal to or better than those covered by statutory health insurance. This depends, however, on the insurance package chosen. In the private health insurance market, premiums vary according to age, sex and medical history at the time of underwriting. Separate premiums have to be paid for spouses and children (ibid.).

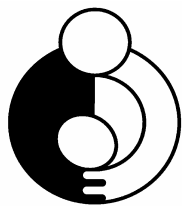
10.4.2 Reimbursement

The following midwifery care is reimbursed: antenatal, natal and postnatal care provided by a doctor or a midwife, medication, costs of the (home) delivery (Scheuermann 1995; Dialoog met de burgers 2000).

10.4.3 Income

Midwives are either paid a salary for employment, paid per client or paid a fee for services. If the midwife is paid a salary, her income is set by her employer (e.g. the hospital). If the midwife is self-employed, her income is dependent on the charges she can collect.

The German midwives estimate their average income to be about €26,610.



10.5 Training

10.5.1 Admission requirements

To enrol on the training course a student must be at least 17 years old, be healthy enough to practice the profession, and possess a diploma of the 'Realshule' or an equivalent examination. Next year, students will need a diploma that is good enough for university.

Six hundred students are admitted to the education annually. There are 57 schools for midwives, which receive too many applications each year. Therefore, there is a waiting period before enrolment.

10.5.2 Colleges

Midwifery-training in Germany takes three years. The course integrates classroom instruction with practical training. The mandatory, minimum requirements before the final examination and becoming qualified, are 1,600 hours of classroom instruction and 3,000 hours of practical training. The practical training consists of working in the delivery room, maternity ward, pediatric department, clinical and non-clinical nursing wards, operating room and independent practice (www.bdh.de). There are written exams, as well as oral and practical exams.

Midwives and physicians manage the schools together. Midwifery colleges are always affiliated to major universities or major city-hospitals. But the government is officially responsible for the training course. There is no tuition. Midwifery students receive a salary from the hospital with which the college is affiliated (BDH 2000; www.bdh.de).

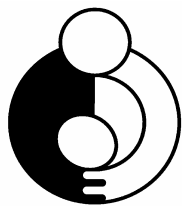
10.6 Developments

10.6.1 Threats

There are a lot of gynaecologists (more than 15,000). Because of the overlapping competencies of gynaecologists and midwives, the job responsibilities of the midwives are threatened. Doctors give antenatal care more often than midwives do. The number of gynaecologists also causes more 'medicalisation'.

Women are badly informed about the possibilities of where to give birth and about their primary care provider. They can choose where to deliver the baby, but 98% of the deliveries still take place in hospital.

Most midwives are dissatisfied with their income.



10.6.2 Opportunities

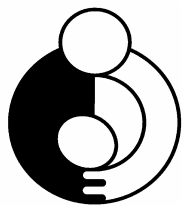
Women *do* have a free choice between a midwife and a gynaecologist, but it is normal to go to the gynaecologist when a woman thinks she is pregnant. If women are better informed about the care provided by a midwife or by a gynaecologist, they might decide differently.

10.7 Statistics

Year	1999	2000
Inhabitants		82,000,000
Birth-rate	770,744	
Born alive	767,691 (99,60%)	
Stillborn	3,053 (0,40%)	
Perinatal mortality rate	0,40%	
Midwives		15,000
Births per midwife		
Gynaecologists		±15,000
General practitioners active in midwifery care		

The perinatal mortality rate is the number of deaths of babies weighing more than 500 grams who have shown signs of life before plus the number of babies weighing more than 500 grams born without a heartbeat, pulsation of the umbilical cord or definite movement of voluntary muscles, until the 7th day postpartum*.

*Paragraph 29, Abs. 2 und 3 der Verordnung zur Ausführung des Personenstandgesetzes 1994.



11. Midwifery in Greece

11.1 The midwife

11.1.1 Tasks and responsibilities

In Greece, midwives' responsibilities are differentiated and depend on the place and sector where they work. In private maternity clinics in the big urban cities, the midwife is involved in antenatal and postnatal care and she helps obstetricians in the labour ward during delivery or an operation. She also takes care of women with gynaecological problems.

In public maternity clinics in the urban cities, the job responsibilities are similar to the ones mentioned above. She also performs other tasks. Only a small number of midwives, who work in a labour ward, conduct spontaneous deliveries.

In public maternity clinics in the rural areas, the midwife takes charge of normal deliveries on her own.

In centres of primary health care, the midwife is sometimes involved in the care of women during pregnancy, birth and postpartum. The activities of those midwives mainly consist of general nursing.

A few midwives co-operate with obstetricians and their responsibility is to educate the woman and guide her and prepare her for labour and birth.

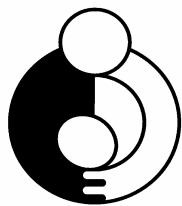
Generally, the tasks of the Greek midwife concern the following:

1. Antenatal check-ups (i.e. temperature, blood pressure, pulse, foetal growth, position, etc.)
2. Delivery monitoring (physical examinations, psychological support, hydration, bladder care, etc.)
3. Postnatal examinations
4. Parental education (i.e. breastfeeding and nutrition).

Midwifery skills are frequently under-utilised and midwives therefore regularly perform tasks below their level of training.

11.1.2 History

The profession of midwives has been protected in law since 1953, as have been their tasks and responsibilities. This law was updated in 1989.



11.2 The midwifery system

In this paragraph, some aspects of the Greece midwifery system are discussed.

11.2.1 View on pregnancy and birth

While the view among midwives is that pregnancy and birth are natural processes, the general prevailing view is that pregnancy and birth are natural processes only in retrospect. In Greece there are no feminist organisations requiring natural birth. This view can be seen in the Greek midwifery system, where 98.9% of all deliveries are actually conducted by obstetricians. And where obstetricians are always ultimately responsible.

11.2.2 Division of tasks

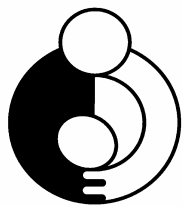
In antenatal care, midwives as well as obstetricians and organised maternity care are active. At the birth, a paediatrician is also available. Midwives and obstetricians participate together in postnatal care.

While a midwife is able to take charge of a normal pregnancy and birth on her own, the obstetrician always assumes the final decisions. He is usually the one who performs the actual birth, while the midwife functions as a subsidiary.

The relationships between obstetricians and midwives are highly charged and traditionally antagonistic. Medical and midwifery staff often have conflicting views on each other's legitimate spheres of practice.

11.2.3 Place of birth

In general, the obstetrician decides where the birth is going to take place. This would be the (maternity clinic in) hospital, unless the parents explicitly demand otherwise. In contrast, the number of home births is insignificant. It is usually an accident if a woman delivers at home.



11.3 Number of professionals

In this paragraph, the number of midwives and gynaecologists will be discussed.

11.3.1 Midwives

In 2000, of the 4,000 registered midwives in Greece, approximately 2,300 practised midwifery. Only 89 of them are male. Most midwives are between 30 and 40 years old, as is highlighted in the next table:

Age	Midwives (%)
<30 years old	25%
30-40 years old	45%
40-50 years old	25%
>50 years old	5%

Table 11.1: Age structure of Greek midwives

Most midwives (60%) work in public hospitals and public maternity clinics and 20% are employed in private maternity clinics. Only 2% of the midwives are self-employed in an independent free practice. The rest (18%) works in centres for general health care where no deliveries are conducted.

11.3.2 Gynaecologists

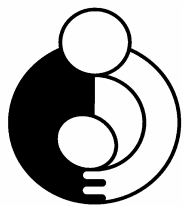
According to the National Statistical Service of Greece there were about 2,176 gynaecologists in 1998.

11.4 Financing and income

11.4.1 Finance system

Greece has 12 health care regions and 52 districts. In 1983 Greece adopted a national health care system that was to unify all public health services under the Ministry of Health and reduce the size and inequities of the private sector. The Greek health care system is highly centralised and regulated. The Ministry has power to regulate almost every issue concerning the financing and provision of health care (Van Kemenade 1997).

The Central Council of Health advises the Ministry of Health but has little influence on health care priorities. At a regional level, similar regional health councils operate, whose role it is to advise the Central Council about the needs of the population and the planning and evaluation of health care services. The regional councils will become more important if a trend of decentralisation gets under way in the next few years.



Below the regional level, a representative of the government operates at a district level. The head of the district administration is a physician who reports to this representative (ibid.).

About 99% of the people are covered by compulsory public insurance organisations (occupation based). The health care system has three main sources of finance. There is direct public provision made through the Ministry of Health, which has its own budget and is mainly responsible for hospital services. Secondly, there are numerous public funds, which provide cover for both hospital and ambulatory services. Furthermore, private insurance is available to cover all sorts of care (ibid.).

The health insurance funds are financed by contributions of employers and employees (75%), except for the large Agriculture Workers Fund which is fully financed by 'earmarked' taxes. The contributions and the range of benefits differ among insurers.

Large funds operate their own polyclinics, health centres and hospitals.

In 1997, 26% of health care was financed through taxes, 32% through social premiums and 42% through private sources (direct payments and voluntary insurance). The market for private insurance is growing. In Greece, one percent of the GNP is spent on maternity care.

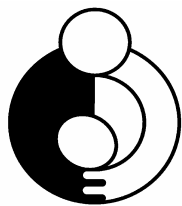
11.4.2 Benefit packages and co-payments

The social insurance funds benefits provide their own benefits packages. But all security benefits provide their members with free cover for outpatient and hospital care services within the public sector. In the case of an admission to a private hospital, the health insurance company reimburses a small proportion of the costs. Since the provision of public health services often fails to meet consumer expectations, patients frequently contribute out-of-pocket payments for private care (Van Kemenade 1997).

With regard to midwifery care, the social insurance funds benefits reimburse laboratory examinations, medical visits, birth and postnatal care in public maternity clinics and medication. There are only a few social insurance funds which also cover charges in the private sector.

11.4.3 Income

The great majority of midwives work as employees, either in the National Health System or in private clinics, and are paid a salary. The Ministry of Health sets the salary of midwives working in public organisations, while the salary of those working in private hospitals is set in a labour contract. Midwives working on a freelance basis earn a fee for each service they provide.



Midwives find that they have a low-paid job, except for those who are self-employed. The Hellenic Midwives Association estimates the average income of midwives in Greece at approximately €11,739.

11.5 Training

11.5.1 Admission requirements

To be admitted to the midwifery-training course, a student has to pass national examinations after finishing secondary school.

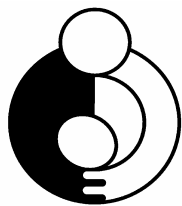
11.5.2 Colleges

It takes the 300 midwifery students eight semesters (each of 14 weeks) in a Technological Educational Institution to become a midwife. This encompasses 4,282 hours in total, of which 1,470 hours are spent on theoretical education. The course is independent of any nursing course.

Examples of subjects that are dealt with during the course, are:

- Human anatomy
- Physiology
- Basic nursing
- Paediatrics
- Neonatology
- Family planning
- Gynaecology
- Gynaecological nursing
- Sociology
- Psychology.

A student has to complete 20 weeks of antenatal practical training and 30 weeks of natal plus 20 weeks of postnatal practical training.



11.6 Developments

The Hellenic Midwives Association aims to improve the standard of care provided to women, babies and their families through the development, education and appropriate utilisation of the professional midwifery role. But Greek midwives face a lot of threats, which obstruct the way to safer birth practices and fulfilment of the needs of the women.

11.6.1 Threats

Generally speaking, medical practitioners dominate the Greek health care system. Society has accorded them the right to this control, and also the right to define the needs of the market. This combination of social and economic control makes their political influence extremely powerful and difficult to oppose. Besides that, and maybe because of that, the relationships between midwives and gynaecologists are highly charged and traditionally antagonistic.

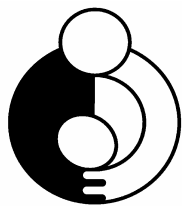
Although there is a law describing quite clearly the autonomous status of the profession of midwives, midwives are often exposed to practices which undermine this belief.

Midwives regularly perform tasks below their level of training. The 'medicalisation' of birth plus the medical ideology that all births are normal only in retrospect, mean that obstetricians have legitimate control over all births. All births are under the leadership of obstetricians and midwives act only in accordance with his policies.

For midwives, this means that they do not often have their own responsibilities. They play a consulting role.

11.6.2 Opportunities

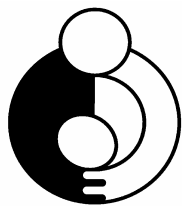
According to the Hellenic Midwives Association, there is nothing positive in the midwifery system. They are waiting for new government regulations on changes in health care provision to be realised. Maybe these will help to strengthen their position and provide other job responsibilities for midwives, so that there will not be so many medical interventions during (normal) pregnancy and birth.



11.7 Statistics

Year	1998	2000
Inhabitants		10,400,000
Births	101,491	
Born alive		
Stillborn		
Perinatal mortality rate	1.5%	
Midwives		2,300 (4,000 registered)
Births per midwife		3
Gynaecologists		2,176
General practitioners active in midwifery care	-	-

Definition of perinatal mortality: The number of stillbirths after the 24th week and 5th day of pregnancy plus the number of neonatal deaths during the first 28 days of life.



12. Midwifery in Ireland

12.1 The midwife

12.1.1 Tasks and responsibilities

Ireland has accepted the definition of a midwife made by the ICM/FIGO/WHO (1992) and the activities of a midwife as laid down in 80/155/EEC Article 4.

A midwife is able to take responsibility for a woman experiencing normal pregnancy and birth independently. She may assist high-risk women with care. In these cases, the midwife shares the responsibility with the gynaecologist.

The Irish midwife also gives parental education.

The profession of midwives has been protected by law by the European Midwifery Directives and the Nurses Act 1985 and by the Health Act 1970.

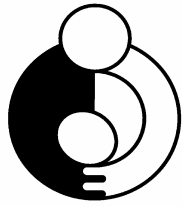
12.1.2 History

In the 1950s, hospital births were less frequent. In 1954, the Government introduced the Maternity and Infant Scheme under the Health Act of 1953. Many women gave birth at home at the time. In the 1960s, this began to change and most births occurred in hospitals. This trend continued until the 1990s, when women began to request home births. But Obstetricians and Health Boards objected to this.

A review of the Maternity and Infant Welfare Scheme took place in 1994 and following recommendations made in this report, centres that offer the DOMINO scheme with early discharge and home births were set up. The National Maternity Hospital in Holles Street initiated this and was followed by Sligo, Galway and now Cork.

Following a ten-day strike of nurses and midwives, the Government set up a Commission on Nursing, which was chaired by Judge Mella Carroll. This group produced a report; among the recommendations for midwifery was the setting up of a Direct Entry Midwifery course. This commenced in 2000 and is a three-year course. The areas involved are the University of Dublin, Trinity College and the Rotunda Hospital School of Midwifery and the School of Midwifery in Our Lady of Lourdes Hospital, Drogheda.

The Nurses Act (1985) is currently being reviewed and will become the Nurses and Midwives Act and will recognise midwifery as totally separate and distinct from nursing.



12.2 The midwifery system

The woman may go to the general practitioner for the first antenatal check-up. Free choice of care provider is a basic principle in the health system. However, most women choose an obstetrician to be their primary care provider. Since the 1960s, midwifery care has become more 'medicalised'. Therefore, midwives have become hospital-midwives and obstetrical nurses.

Midwives' clinics exist in some Maternity Hospitals and provide care for low risk women.

12.2.1 View on pregnancy and birth

Society feels that pregnancy and birth are potential pathological processes. They feel that there are potential risks to mother and child. Midwives sometimes see pregnancy and birth as potential pathological processes and sometimes as natural processes. But the overall view fits the trend of 'medicalisation' and the fact that midwives have become hospital-midwives and obstetrical nurses.

12.2.2 Division of tasks

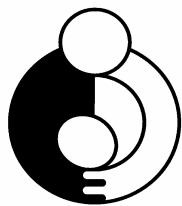
The gynaecologist is not always present at the birth. He is just present in the background. The midwife can contact him if there are problems. Then she will assist the gynaecologist. The midwife is completely responsible for her own performance.

12.2.3 Place of birth

In Ireland, 99.6% of all births take place in hospital.

There are approximately two hundred home births a year. Legally, women have the right to give birth at home, but for 30 years they have been more or less obliged to deliver in the maternity clinic where their gynaecologist works. In those institutions, at least 2000 deliveries a year take place under the responsibility of the gynaecologist (O'Conner 2000).

Home births are at the parents' request. They are conducted under the supervision of an independent midwife. 0.4% of all deliveries take place at home.



12.3 Number of professionals

In this paragraph the number of midwives, gynaecologists and general practitioners who are active in midwifery will be discussed.

12.3.1 Midwives

The number of midwives is not known exactly, because there is not a separate register for midwives. In 2000, the total number of midwives and nurses together was 39,000. The number of midwives can not be estimated. In the future, it will be possible to see the number of midwives, because there is going to be a separate register for midwives.

11 Midwives work in independent free practices, the remainder work in the public sector. They are employed in hospitals, in delivery rooms and maternity clinics.

12.3.2 Gynaecologists

In 2000, there were 81 gynaecologists-obstetricians in Ireland.

12.3.3 General practitioners

The total number of general practitioners that are active in midwifery care is unknown.

12.4 Finance and income

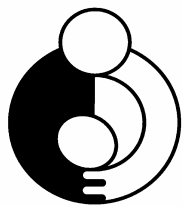
12.4.1 General insurance system

The Irish health care system was regulated in the Health Act of 1970. It is a centrally controlled and financed system that is accessible to the whole population.

The public health services are funded mainly through general taxation, supplemented by a health levy of 1.25%, which applies to all earnings (Van Kemenade 1997).

The services are provided to the citizens in accordance with the following eligibility categories. Category 1 (37% of the population) is concerned with people who are unable, without undue hardship, to arrange medical treatment for themselves and their dependants and those whose family annual income falls below a particular level. People in this category are entitled to free hospital care, free general practitioner services, free drugs and free access to the services available (ibid.).

Category 2 (63% of the population) concerns people whose annual family income is above the category 1 level. Patients in this category are predominantly the employed, but farmers and other self-employed people can be entitled to this by paying a relatively small sum. Category 2 patients are entitled to various co-payments for



hospital care, consulting treatment in public wards or as outpatients, general practitioners and for drugs, although if the costs are high they may obtain a refund from the health board (ibid.).

Most people in category 2 are members of the Voluntary Health Insurance (VHI) scheme, which covers, at least to some extent, hospital treatment. The coverage depends upon the premium paid.

The Voluntary Health Insurance Board is the monopoly provider of health insurance. The VHI is financed through premiums of the insured and through state subsidies.

78% of health care is financed through taxes, 9% through premiums via the Voluntary Health Board and 13% through (other) private financing. Private insurance is voluntary and approximately 35% of the population choose to purchase private health insurance.

The underlying principal reasons for private insurance are, for example, freedom of choice of doctor and hospital, and speedy access to treatment (ibid.).

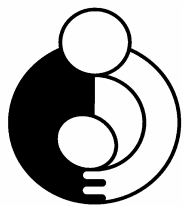
There is a very delicate balance in Ireland between public and private health care, with a great deal of interdependence between the two sectors. Firstly, the public system depends on the existence of private health insurance, because those who take out private insurance continue to support the public system through their tax payments, and the majority will forego their entitlements under this. Secondly, the budgets of the public hospitals are supported by revenue from designated semi-private and private beds. And thirdly, the coexistence of public and private practices in publicly funded hospitals helps to ensure that good doctors are available to public as well as private patients (ibid.).

12.4.2 Benefit packages and co-payments

Women are entitled to midwifery and maternity care, provided by their local health care centre. But there are two possibilities, depending on the category the woman belongs to.

If the woman belongs to category 1, all services are free. The services include midwifery care, maternity care and care for babies until six weeks old and a maternity allowance for each child.

If the woman belongs to category 2, she is entitled to midwifery care, maternity care, infant welfare, and the care provided by the general practitioner during the pregnancy and up to six weeks after the delivery (Dialoog met de Burgers 2001).



12.4.3 Income

Midwives are either paid a salary if employed or paid fee-for-service if independent.

The national government sets the level of the salaries of midwives employed in hospitals. Independent midwives form contracts with insurers about the fee for each service.

The local social insurers have stopped paying directly to the midwife. They now comply with the law by paying the pregnant woman an allowance (€825) if she gives birth at home. Private insurers deny the right of midwives to receive payment for their services. Instead of direct payment to the midwife, they grant an allowance to the parents (€381-667) for a home delivery. The average tariff, a midwife in Dublin asks for antenatal, natal and postnatal care at home with the mother is €1,524 (O'Conner 2000). The mother has to pay the midwife directly.

It is not possible to determine what the average income annually is for a midwife, because there are several salary scales.

12.5 Training

12.5.1 Admission requirements

To enrol on a midwifery course, a student must be registered as a general nurse and have post qualification experience.

There are approximately 140 new students each year, distributed around seven schools.

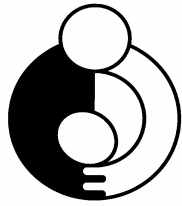
A Pilot Direct Entry (vocational) Midwifery Course commenced in June 2000.

12.5.2 Colleges

Training to become a midwife takes two years. The students have to complete about 1,014 hours of theoretical training and 2,574 hours practical experience. The practical hours are divided into 11 weeks minimum of antenatal care, 18 weeks minimum of intra partum care and 16 weeks minimum of postnatal care.

The midwifery course complies with the European Union Directives (see also United Kingdom).

The hospital and the university are responsible for the training course.



12.6 Developments

12.6.1 Threats

There is poor postnatal care. This means that there is a threat to the continuity of care. Another consequence of this discontinuity are perhaps the low breastfeeding rates.

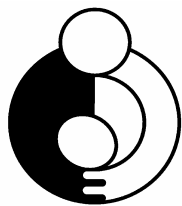
Practically, women are restricted in where to give birth.

Midwifery care has become more 'medicalised', and midwives have become hospital-midwives and obstetrical nurses. This undermines their position as independent professionals.

Most of the time, the gynaecologist is only present at the delivery when the midwife calls him (if she needs him). But if it is a private patient of the gynaecologist, the midwife always has to consult him, because the patients pay for this. So even if the midwife does not need the gynaecologist, she is obliged to consult him. This again threatens the midwife's status as an independent professional.

12.6.2 Opportunities

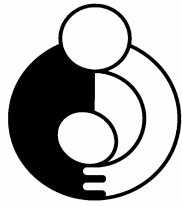
Every woman is entitled to free care. And also free choice of a care provider is a basic principle in the health system. However, most women choose an obstetrician to be their primary care provider. According to the midwives, this should be changed; women should choose a midwife to be her primary care provider. Care provided by a midwife is reimbursed. There is also a high standard of midwifery care and this contributes as one of the factors to low perinatal mortality. These characteristics should make it possible for a midwife to strengthen her position and to make her the primary care provider for midwifery care.



12.7 Statistics

Year	1997	2000
Inhabitants		3,500,000
Birth rate		54,239
Born alive	53,971	
Stillborn		
Perinatal mortality rate		0.50%
Midwives		39,000 (incl nurses)
Births per midwife		
Gynaecologists		81
General practitioners active in midwifery care		

The perinatal mortality is the number of stillborn and deaths from week 24 of the pregnancy until the first week of life.



13. Midwifery in Italy

13.1 The midwife

13.1.1 Tasks and responsibilities

A midwife is a health care worker, with a university diploma and a licence. She helps and counsels women during pregnancy, birth and postpartum. She is entitled to deliver first assistance medical care and drugs. She participates in health and sexual education, gynaecological treatment, prevention activities and also in professional training, a midwives' course and research.

The tasks of the Italian midwife concern the following:

1. Surveillance and management of normal pregnancy and birth
2. Counselling
3. Prevention (e.g. urinary incontinence)
4. Parental education (e.g. parenting skills and breast-feeding)
5. Postnatal newborn and mother's treatment.

There might be some differences between job descriptions at hospitals. Responsibilities also depend on the outcome of the situation.

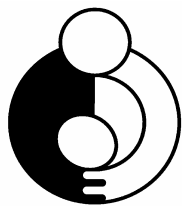
A midwife in hospital and a gynaecologist share the final responsibility for normal pregnancies and births, even when the midwife is on duty. The midwife usually conducts the actual birth, except in the case of a pathological situation. She then assists the gynaecologist.

A self-employed midwife (or freelance midwife) is allowed to take care of a pregnant woman. However, some tasks are exclusively reserved for the gynaecologist. Examples of these are echography, exam application, pathological situations, etc.

The profession of midwives is protected by law, as are their competencies. In fact, all health activities and professional positions are defined in the Law on the Italian National Health System.

13.1.2 History

Since 1888, the law has been protecting the profession of midwives. Italian midwives have had an Edict for their functions and activities since 1890.



13.2 The midwifery system

In Italy, several professional groups are active in midwifery care. Besides the midwife and the gynaecologist, the general practitioner and organised maternity care are active in antenatal care. The midwife, gynaecologist and maternity care provide natal care. And postnatal care is given by the midwife and the gynaecologist, as well as by the paediatrician, the general practitioner, the maternity care provider and an infant nurse.

13.2.1 View on pregnancy and birth

The prevailing view on pregnancy and birth in Italy is that these are natural processes in life. This is not always reflected in aspects of the midwifery system.

13.2.2 Division of tasks

A midwife and a gynaecologist share the final responsibility for normal pregnancies and births, even when the midwife is on duty. The paediatrician is also responsible for care in the postnatal phase.

The midwife always conducts a physiological birth in the presence of the gynaecologist. It may happen that he is in another room, but the gynaecologist is always at hand, to function in a pathological situation or to suture the perineum if necessary. Because every head-gynaecologist is free to organise the activities in his maternity unit, some differences in these practices may exist.

In the case of an abnormal pregnancy and birth, a gynaecologist is ultimately responsible, together with the organised maternity care and also the paediatrician in the postnatal phase.

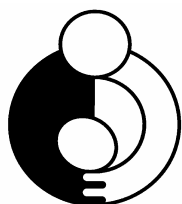
It is common for a woman to go to a gynaecologist when she is pregnant. She is free to choose between gynaecologists either in a private or in a public sphere (county ambulatory or hospital ambulatory). Women seldom opt for going to a midwife first.

13.2.3 Place of birth

All deliveries take place in hospital. Only if the parents explicitly ask for a delivery at home or in a maternity clinic, does the delivery take place there. That is, if it concerns a normal pregnancy. The percentage of home deliveries is 1%.

13.3 Number of professionals

In this paragraph, the number of midwives and gynaecologists will be discussed.



13.3.1 Midwives

In the year 2000, there were approximately 14,500 midwives practising midwifery in Italy, of which about 14,000 (or 96.5%) were female.

Most of the midwives (80%) work in the public National Health Service (NHS) sector, which means they are employed in public hospitals, university hospitals and/or a 'consultorio' in the country. It is not very common for midwives to work in independent free practices. There are only about 120 midwives (10%) who do. Another 10% work in the private sector of a hospital, clinic or ambulatory.

The age groups, comprising an equal number of Italian midwives in each category, are highlighted in the following table:

Age	Midwives (%)
22-30 years old	15%
31-40 years old	30%
41-50 years old	25%
51-60 years old	20%
61-older	10%

Table 13.1: Age structure of Italian midwives

13.3.2 Gynaecologists

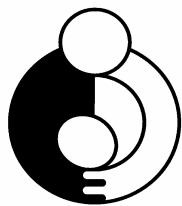
The number of gynaecologists was estimated at 12,000 in the year 2000.

13.4 Financing and income

13.4.1 Finance system

In recent years, the Italian National Health System has undergone a series of changes and modifications. The National Health Service (Il Servizio Sanitario Nazionale:SSN) was established in 1978, and replaced a system of more than 200 health insurance schemes. The law now provides universal coverage and comprehensive free health care at the point of delivery (Van Kemenade 1997).

Health care is regulated at different administrative levels. At the national level the Ministry of Health establishes a legal, operational and financial context for the health care services. Italy has an annual health care budget set by Parliament. The 20 regional health authorities are responsible for the provision of health services in their regions. They must draft a regional health plan and evaluate the efficiency of regional health services (ibid.).



These regions are responsible for all activities in the field of health care and they have considerable autonomy. They exert influence on the way services are delivered at a local level and they negotiate contracts with private hospitals and teaching universities (ibid.).

In 1996 the regions were divided into 228 local health areas under the authority of Azienda Sanitaria Locale (ASLs). The local level is the operational part of the system and runs health care programmes and facilities.

The Italian National Health Service is financed by a National Health Fund. The most important source of funding are the social insurance premiums (50.5%). General taxation accounts for 42%. An out-of-pocket combined contribution by the citizen and other kinds of co-payments contribute respectively 4.2% and 3.3%. These sources of finance account for 73% of all health care costs. The rest (27%) is paid for through the voluntary system, meaning out-of-pocket payments and voluntary insurance for extra or more luxurious care.

At the beginning of each quarter, payments are transferred to the regions, which in turn allocate funds to the local health areas. Private insurance mainly provides supplementary cover (Van Kemenade 1997).

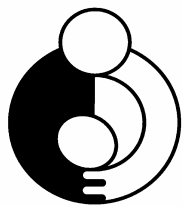
13.4.2 Benefit packages

The SSN aims to ensure that all citizens have access to both primary and secondary care. There are few exclusions (dental care and plastic surgery). Since 1992, the regions have had to provide a minimum level of health care. But regions can make additions to this minimum, meaning that different regions can have different benefit packages. All care included in these packages is free. Parents who want other care or extra services have to pay for it themselves, or they can choose to enclose supplementary insurance (Van Kemenade 1997).

In principle, all midwifery care provided in the public health care sector is paid for (i.e. enclosed in the benefit packages). Parents sometimes arrange supplementary insurance for care provided by a self-employed midwife or for extra and more luxurious care.

13.4.3 Income

Midwives in hospitals are paid a salary for employment. The level of their income is determined by negotiations between the trade unions of the national health care employees and the national government. Regional health authorities and local health authorities can add a certain amount to the income, after negotiating with a regional trade union. This is because in the different regions of Italy there are different



quantities and quality of work. Self-employed midwives earn a fee per client of which the amount is set by the Midwives' Order for free services.

The annual average income of Italian midwives is estimated at nearly €15,500.

13.5 Training

13.5.1 Admission requirements

In order to be admitted to the midwifery course, a student must have a high school diploma. This diploma is necessary for admission to a university course.

13.5.2 Colleges

The midwifery-training course takes three years, in which 1,600 hours of theoretical training and 3,800 hours of practical training must be completed before graduation. The practical training is made up of 800 hours concerning antenatal care, 2,000 hours of natal care and 1,000 hours of postnatal care.

There are 700 students who study midwifery at the universities.

In 2001 a new law will set up a new system of midwifery education. There will be a first level degree for students completing three years of training, and a second level degree (an extra two years) to become a teacher and head of staff. In this new education system, a student must earn 180 credits to get a first level degree. After 5 years of work experience, she can earn another 120 credits in order to get a second level degree. One credit represents 30 hours of education.

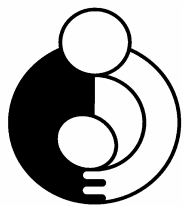
13.6 Developments

Important developments affecting midwives in their current situation will result in new opportunities as well as threats to the midwifery profession.

13.6.1 Threats

The Italian Midwives' Federation considers the high Caesarean section rate as a negative aspect of the Italian obstetric system. It seems to be an indication of the 'medicalised' way of thinking in midwifery care, which hinders a more physiological and natural approach. The fact that women go and see a gynaecologist first when they are pregnant might be another indication of this way of thinking.

According to the Federation there is little attention in the media, as well as from politicians paid to the obstetric system in general and more specifically the midwifery



profession. Therefore, it is hard for midwives to get support or consideration when they are in need of change.

Furthermore, there is no integration between hospital and countryside activities. Therefore, women who receive antenatal care in country surroundings feel lost when they go to hospital to deliver. Moreover, they are 'unknowns' there. There is no data available of women between hospitals and the countryside. That is why there is an overlapping of care resulting in a waste of money and work.

13.6.2 Opportunities

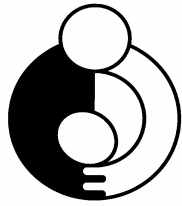
In order to counter the threats and to strengthen the position of Italian midwives, the Federation aims to increase the number of midwives and to increase the number of courses for continuous training and education. A first step with regard to the latter has been made with the new law on education (13.5.2). Midwives will play a more important role in professional training.

The Federation wants to establish more autonomy and responsibility for midwives. And they want to improve the quality of midwifery care. Therefore, it is a positive thing that all pregnancies, births and postpartums are already well managed. And also, that the percentages of perinatal mortality and morbidity are low.

13.7 Statistics

Year	1999	2000
Inhabitants		57,200,000
Births	525,428	
Born alive	523,463 (99.6%)	
Stillborn	1965 (0.37%)	
Perinatal mortality rate	0.40%	
Midwives		14,500
Births per midwife		
Gynaecologists		12,000
General practitioners active in midwifery care		

According to the umbrella organisation the definition of perinatal mortality is the number of stillborn and deaths in the first week of life.



14. Midwifery in Luxembourg

14.1 The midwife

14.1.1 Tasks and responsibilities

Theoretically, in accordance with the EU-directives, a midwife in Luxembourg is a professional, taking responsibility for women and families throughout pregnancy and birth in a physiological situation and assisting the gynaecologist in a pathological situation. But in practice, the medical profession assumes the final responsibility.

In short, the tasks of a midwife from Luxembourg consist of:

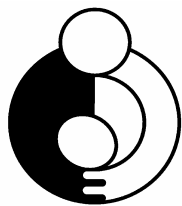
1. (Parenting classes)
2. Complete care during delivery
3. Assistance during birth
4. (Postnatal care)
5. Guidance in breast-feeding
6. (Neonatal) Intensive care.

Nearly all midwives work in delivery rooms and maternity wards in hospitals. In the antenatal phase, they only see pregnant women for CTG-scans in the last week of pregnancy, or if women come in for problems such as bleeding. Some midwives do parenting classes for the hospital, but gynaecologists are primarily responsible for antenatal care.

During labour, a midwife is completely responsible. She keeps in contact with the gynaecologist and she calls him for the actual birth or if there is a problem or a demand for epidural anaesthesia. Here too, the gynaecologist is ultimately responsible together with a paediatrician.

In some hospitals, midwives perform postnatal care. General nurses, paediatric nurses and auxiliary nurses usually deliver postnatal care. Midwives are responsible for domestic care, dealing with such things as early discharge or problems with breastfeeding.

Some midwives are employed in a gynaecological/ high risk pregnancy unit or in a neonatal unit.



14.1.2 History

The profession of Luxembourg midwives has been protected by law since 1967. From 1981 onwards, the education requirements and competencies of the midwives were regulated too.

In Luxembourg, midwifery used to be a 'healing-art-profession' (art de guérir) together with doctors, dentists, pharmacists and veterinarians. In 1967, a new law put the midwives together with nurses and other paramedical professions, as there were less and less independently working midwives. Midwives were only employed in hospital settings, because of the regular income and the prospect of a pension.

Midwives did not put forward any opposition to the new law, because they were glad to be employed. Fees for home births and home visits were “forgotten” in the law, because these were no longer used.

In the 70's, a law protecting women during pregnancy allowed them a certain allowance to see a gynaecologist at least five times, and a dentist once during pregnancy. After the birth, they had the right to visit the gynaecologist once more plus the right to regular medical check-ups for the child until it was two years old. This law assured reimbursement (by the social security office) of maternity care, but only the care given by doctors. It was part of a preventive programme, financially supported by the government.

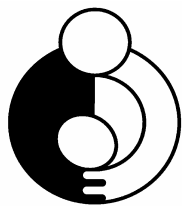
Several aspects of the law were changed in 1995 in order to adapt to European directives. Midwives then managed to insert two new articles, stating that pregnant women can pay some supplementary visits to a midwife during pregnancy and after birth. It also stated that a new regulation had to be made, to define the conditions for these visits. Midwives have been pushing the government and the gynaecologists to produce this regulation ever since. But it still has not happened.

14.2 The midwifery system

Several professional groups are active in the Luxembourg midwifery system. As well as midwives and gynaecologists, there are also general nurses, paediatric nurses, auxiliary nurses and paediatricians involved.

14.2.1 View on pregnancy and birth

Paragraph 1 reveals that the medical profession of gynaecologists is mainly responsible for midwifery care. This is because pregnancy and birth are seen as medical concerns, which put all women at risk. Even some midwives like to rely on the gynaecologists, according to the Luxembourg Association of Midwives.



14.2.2 Division of tasks

Antenatal care is mainly provided by gynaecologists. They also usually conduct the births in hospital. It is impossible to find out what percentage of births are carried out by midwives, because this depends on the hospital organisation and on the gynaecologist being on time. General nurses, paediatric nurses and/or auxiliary nurses often provide postnatal care.

There are two independent gynaecologists who each employ a midwife to do things like CTG-scans, parenting classes and even some antenatal and postnatal visits.

It should be noted that the gynaecologist and the paediatrician are usually ultimately responsible.

14.2.3 Place of birth

Parents are supposed to be able to choose the place of birth, but in reality, the gynaecologists decide about this. Deliveries therefore take place at the hospital where the gynaecologist concerned works, except if parents explicitly ask for a home birth. However, it is a political decision, initiated by gynaecologists, that home births are not reimbursed. This contributes to the fact that there were only two home births in the year 2000.

14.3 Number of professionals

In this paragraph, the number of midwives and gynaecologists will be discussed.

14.3.1 Midwives

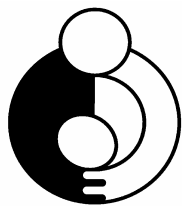
There were about 97 registered midwives in Luxembourg in the year 2000, of which 60 to 70 were practising midwifery actively. So this means that there are about 0.5 midwives per 1,000 fertile women.

There is only one midwife who works fulltime independently in a free practice. Fourteen midwives work part-time independently. The rest work in public hospitals.

The fifteen independent midwives see each other regularly to discuss problems, plan holidays, see who is covering which area and so on. Some form a 'baby-friendly' team, meaning that they "handle" breastfeeding as recommended by the WHO/UNICEF initiative 'Baby-friendly hospital'.

14.3.2 Gynaecologists

The number of Luxembourg gynaecologists was estimated at 70 to 80 in the year 2000. Every gynaecologist has some kind of contract with a hospital.



14.4 Financing and income

14.4.1 Finance system

The fundamental principles of the Luxembourg health system are a free choice of the provider by the patient, compulsory health insurance and compulsory provider compliance with the fixed fees-for-service fixed in the insurance system (European Observatory 1999).

In Luxembourg, two governmental departments are involved in health care. The Ministry of Health being responsible for the organisation of hospitals, preventive care and social medicine and the Ministry of Social Security supervising the health insurance schemes. The organisation of the health care system is centralised and practised in a context broadly determined by a free practice of the medical professions and an extended role for the private sector (Van Kemenade 1997).

Public health insurance is administered by nine sickness funds, each of which is targeted at a different professional group. The main objective of the sickness funds is the provision of services to persons insured. In addition, they manage their existing assets.

The Union of Sickness Funds is responsible for: negotiating agreements/contracts with health care providers, drawing up the annual budget for sickness and maternity insurance, revising the contribution rates and so on (ibid.).

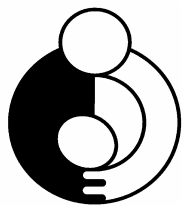
The method of financing health and maternity insurance follows the contributory model. Since 1992, financial intervention by the state has been determined in accordance with contributions paid by the insurer (and by employers in the case of salaried employees) and no longer on the basis of the payments made (Van Kemenade 1997).

Contributions are levied on incomes below an upper limit. For salaried employees, the rate of contributions is shared equally between the insured and employers.

Of the total health expenditure, about 59% is financed through contributions, 39% through taxes and 2% through private payments. Private health insurance covers certain charges not refunded by the sickness funds.

14.4.2 Reimbursement

The benefit packages and co-payments are the same for all sickness funds. Health care benefits are granted either in the form of a reimbursement by the sickness funds to the insured or by the Union of Sickness Funds paying the bill directly. Public care



financed directly by the government through taxes, such as maternity care, is free of co-payments (Van Kemenade 1997).

So, a basic 'birth package' is available for everyone, which includes, in particular, treatment by gynaecologists, care provided in the hospital, the stay in the hospital and medication. The tasks of midwives include only postnatal care at home if it is a case of an early discharge (before day 4 after the birth) and treatment with a prescription from a doctor (for example, home visits after day 4 in the case of breastfeeding problems). Parents can choose to enclose supplementary insurance for more luxurious care, such as a one-bed-room and epidural anaesthesia. The sickness funds do not reimburse antenatal care provided by a midwife and home births. In fact, gynaecologists will do everything to make sure that insurers will not pay midwives for this kind of care in the future too.

14.4.3 Income

For employed midwives there is a collective agreement on their salary like there is for all caring professionals. Trade unions negotiate these agreements every five years. In the meantime, wages are rising due to market trends or the 'living index'.

A midwife collects a fee-for-service or a fee per client for things that are not covered by social security. For independent midwives the fees are negotiated every year by a commission, represented by one midwife.

In Luxembourg, a midwifery salary is circa a middle to upper class income; approximately €30,000 before taxes annually. But there are barely any opportunities to make a career for herself.

14.5 Training

14.5.1 Admission requirements

Midwifery-training is a two-year complementary course to the three-year general nursing course. There are no further admission requirements.

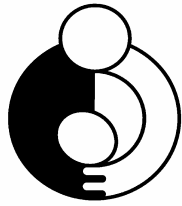
Every two years, ten new midwifery students are admitted to the course.

14.5.2 Colleges

Midwifery students have to complete 700 hours of theoretical training and 2,300 hours of clinical (i.e. practical) training.

The theoretical training consists of such lessons as:

- Anatomy



- Embryology
- Gynaecology
- Normal and abnormal pregnancy, birth and postpartum
- Anaesthetics
- Pharmacology
- Paediatrics
- Nutrition
- Psychology.

A student has to do all the activities written in the midwifery directives, for example, to actively perform 40 deliveries. The student will gain experience in the delivery room, in the (neonatal) intensive care unit, in the high-risk pregnancy unit and in the maternity wards.

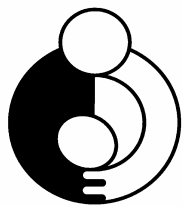
The Ministry of Education is responsible for the school. The Ministry of Health accounts for the curriculum, the examination and graduation.

14.6 Developments

The Luxembourg Association of Midwives is trying to establish the midwife as a professional, who can take responsibility for herself in a physiological situation and who assists the gynaecologist in case of pathological problems. Therefore, the midwifery profession needs to be supported and strengthened. In the current situation, several threats hinder this development. But there are also some opportunities.

14.6.1 Threats

In a way, midwives are still considered as a less valuable professional group than physicians are. Despite the promise of a new law on extended competencies in 1995, no attempts have been made since then. Gynaecologists work hard against the development of this law through their political influence. So, tasks performed by midwives are still only reimbursed with a prescription from a doctor, and the sickness funds do not pay anything for antenatal care provided by a midwife and for home births. As a consequence, women in Luxembourg are not free to choose their primary care provider. They all go to a gynaecologist when they are pregnant.



There is a strict law stating that hospitals are allowed to have a maternity unit. A small unit is to be closed and maternity centres or midwifery led units can not be authorised.

The view that pregnancy and birth are natural (physiological) processes in life has not been assimilated into the Luxembourg obstetrical system just yet. In fact, most pregnant women are considered at risk.

The Ministry of Education is actually attempting to reduce the admission requirements for midwifery-training to a two-year nursing course, instead of a complete three-year curriculum leading to a nursing diploma. The midwifery Association is strongly opposed to this. The proposition would be in conflict with the European directives and would lead to a more poorly prepared midwife with the risk of providing care of a lesser quality.

14.6.2 Opportunities

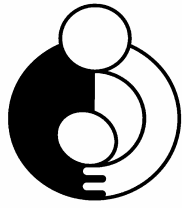
As the costs for health care are growing, decision-makers can only come to the conclusion that midwifery care provided by midwives is cheaper than medical care provided by gynaecologists. According to the Association, “Normal pregnant women just need to see a midwife and then costs can be kept at an acceptable level”.

14.7 Statistics

Year	1999	2000
Inhabitants		435,700
Births	5,596	
Born alive	5,582 (99.7%)*	
Stillborn	14 (0.3%)*	
Perinatal mortality rate	0.52%	0.7%
Midwives		60-70 (97 registered)
Births per midwife		
Gynaecologists	61*	60-70
General practitioners active in midwifery care	-	-

According to the umbrella organisation the definition of perinatal mortality is the number of stillborn plus the number of deaths from the moment the gynaecologist perceives the foetus as a potential living baby, to one week after birth.

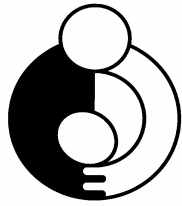
The perinatal mortality rate fluctuates greatly every year, due to the low number of births, for example: 0.81% in 1998.



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& Touche**

* Statec; Service Central de la Statistique et des Etudes Economique.

The number of midwives and gynaecologists was estimated in 2000.



15. Midwifery in the Netherlands

In the Netherlands, midwives can work in primary or secondary care. Midwives who work in secondary care, are employed by the hospital. Because most midwives work in primary care, this chapter will concentrate on that.

15.1 The midwife

15.1.1 Tasks and responsibilities

In the Netherlands, there is a clear division of tasks in primary and secondary midwifery care, based on the dichotomy between physiology and pathology. The midwife (or general practitioner) in primary health care conducts the normal pregnancy and birth. She is in charge of the prevention and selection of pathology. In the case of a pregnancy or birth with an increased risk, the midwife consults and/or refers to a gynaecologist in secondary health care.

The midwifery profession has been protected since 1995 by a law on individual health care (BIG). According to this law, a midwife has to be registered in the BIG-register. In this law, such things as the skills and competencies of midwives are constitutionalised, as well as their reserved operations.

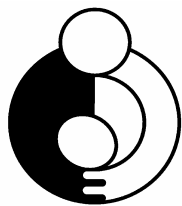
According to the description of the Royal Dutch Organisation of Midwives (KNOV), the midwife is completely and medically responsible for antenatal, natal and postnatal care and a check-up six weeks postpartum for low- and medium-risk midwifery. The midwife also has a duty in the area of family planning (Crébas 1992).

According to the KNOV, the midwife is the only paramedical professional that one can consult without a referral. She has the autonomous power to judge and decide on the supervision concerning the physiological pregnancy and birth (ibid.).

The midwife integrates psychosocial guidance into her work. This implies attention to the personal, social and cultural background of the pregnant woman.

In practice, the midwife has three main tasks:

1. The midwife is able to take responsibility for a normal pregnancy and birth independently (This concerns the home delivery and the polyclinical delivery)
2. The midwife should recognise and deal with medical and non-medical risks (If there is a risk, the client should be referred to the gynaecologist at the right moment)



3. The midwife, if in doubt, should decide whether consultation of the gynaecologist is necessary. She decides that on the basis of certain criteria (the midwifery list of indications) (Crébas 1992).

15.1.2 History

The position of midwives has often been under discussion. In 1969 Dr. Pannekoek wondered if midwives and home deliveries would still exist in the 21st century. Yet, the position of midwives has improved. Nowadays, it can be said that the midwife and the home delivery still have a future.

In 1920, the training course was extended from two to three years. There were two reasons for this supplementary year. Firstly, it was thought that the pressure on the students to learn midwifery in two years, was too high. Secondly, it meant that there would be more attention paid to neonatal care, maternity care and social hygiene (Drenth 1998).

Because of educational and technical developments, the curriculum was reviewed in the 1970s. The shortage of midwives made it necessary to increase the number of students each year (Schoon 1998).

In 1993 the course became four years in duration.

15.2 The midwifery system

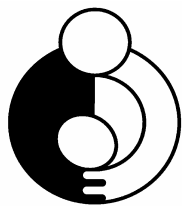
15.2.1 View on pregnancy and birth

In the Netherlands, both midwives and society see pregnancy and birth as natural processes. Most gynaecologists also see pregnancy and birth as natural processes.

The midwife plays a key role in the perinatal period. She has to deal with very diverse questions. That is why the midwife has contact with a lot of other (medical) professionals.

If it concerns extramural care, the midwife has contact with organised maternity care, the district nurse, the health centre, the dietician, the physiotherapist, social work and domestic care. If it concerns intramural care, the midwife has contact with the gynaecologist, the paediatrician, the nursing staff, maternity ward, neonatal ward and intensive care unit (Crébas 1992).

In this paragraph, we will discuss the professional groups that are involved in care during pregnancy or birth. In the Netherlands, midwives, (some) general practitioners, gynaecologists and organised maternity care are involved.



15.2.2 General practitioners active in midwifery care

General practitioners, like midwives, have the authority to handle pregnancies and births. The number of general practitioners that are active in midwifery care is decreasing; this is also due to the 'primate' of midwifery. The primate will be discussed in paragraph 4.3. Only general practitioners that conduct both pregnancies and births are called general practitioners active in midwifery care (Wiegers & Hingstman 1999). General practitioners have to conduct at least ten deliveries a year, to stay active in midwifery.

15.2.3 Gynaecologists

If the pregnancy is abnormal, the gynaecologist is the obvious person to deliver the baby. Of course, gynaecologists have a broader range of tasks than just midwifery care. About 40% of their total working hours is spent on midwifery care (Welling et al. 1999).

15.2.4 Organised maternity care

Maternity care is the care for mother and child after the delivery. In the Netherlands, maternity care is mostly provided at home, and it is one of the 'keystones' of midwifery in the Netherlands. There should be a medical reason for getting maternity care provided in hospital (as well as a medical reason for delivering in hospital) (Hessing-Wagner 1991).

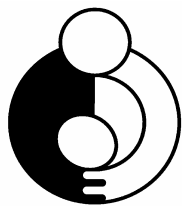
Organised maternity care is provided by maternity centres, which are often merged with home care organisations.

15.2.5 Division of tasks

In the Netherlands, there is a clear division between primary and secondary midwifery care. It is important that women at a higher risk are referred to a gynaecologist in time. It is also important that low-risk women are sent to primary care, because the costs for primary care are lower than the costs for secondary care. Furthermore, guidance in primary care prevents 'medicalisation' of the pregnancy and birth.

The midwifery risks selection involves the selection of pregnant women for primary or secondary care or for an intermediate form. An intermediate form means: 'shared care during the pregnancy' and 'a medium-risk situation'. Since 1998 there has been a consensus on the risks. All professional groups support the midwifery list of symptoms as it is recorded in the midwifery handbook.

In primary care, the midwife is responsible for the client. She is also responsible for the referral of the client to secondary care. In secondary care, the gynaecologist takes



over responsibility. The one who treats or guides the woman is responsible. Even if the gynaecologist has referred a woman back to the midwife, and something goes wrong, then the midwife is responsible. The woman is after all under her supervision, so the midwife has to check again to see if there are signs or symptoms for a new referral.

As has already been said, general practitioners are also allowed to perform deliveries. It has been estimated that in 1999 10.4% of all deliveries were conducted by general practitioners that are active in midwifery and about 50% by gynaecologists. Home deliveries are mainly conducted by midwives, hospital deliveries are mainly conducted by gynaecologists.

15.2.6 Place of birth

In the Netherlands, there are four possible places where women can deliver their babies. At home, in a clinic or in a polyclinic at the hospital, or at a special maternity hotel.

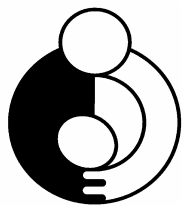
One of the features of the Dutch system is the relatively great freedom of choice of the clients.

Interest in home deliveries over the last few years has been quite stable. In the last decade the percentage of home deliveries has stayed at approximately 30%. There are two conditions for being able to deliver at home. It must be a normal delivery and the woman has to be able to get to the hospital quickly (15 minutes), in an emergency (SMV 2000).

For hospital deliveries there are two possibilities. A woman can have a clinical delivery, in which case she stays in hospital for more than 24 hours; or a woman can have a polyclinical delivery, in which case she goes home immediately after the delivery (Hessing-Wagner 1991).

The polyclinical delivery is conducted by a midwife, because it is a normal delivery and it is an alternative to the home delivery. But also pathological deliveries, conducted by a gynaecologist, could be polyclinical, because women need to show certain symptoms in order to get maternity care at the hospital (Hessing-Wagner 1991).

Giving birth in a special maternity hotel is called a 'moved' home delivery. A woman can only give birth in this hotel if she has no medical problems, because at the hotel there is no medical equipment. The midwife conducts this delivery.



15.3 Number of professionals

In this paragraph the number of midwives, general practitioners active in midwifery, gynaecologists and maternity care are discussed.

15.3.1 Midwives

As of January 1st 2000 there were 1,578 practising midwives, of which 44 (2.8%) were male.

Most of the midwives work independently in primary midwifery care (69%) in their own practices. About 16% of midwives work in secondary care at the hospital and 247 (15%) midwives work as observers. They take over another midwife's practice if she is ill or during holidays. 12% of midwives with their own practice work solo; 22% work in a duo-practice and 66% in a group-practice (Hings tman 2000).

The density of midwives is the average number of women between the ages of 15 and 39 per one independent midwife. This means that there is one midwife for 2,069 women in their fertile years (Hingstman 2000).

15.3.2 General practitioners active in midwifery care

Studies show that 16% of general practitioners are active in midwifery care, 22% just deal with the first 12 weeks of the pregnancy and 61% conduct no pregnancies at all. As of January 1st 1999 there were approximately 1,120 general practitioners active in midwifery (Wiegers & Hingstman 1999).

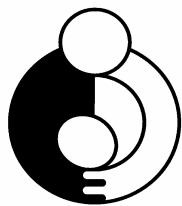
Most of the time, general practitioners in the countryside are active in midwifery (because there is no midwife). On the other hand, the number of general practitioners active in midwifery in urbanised areas is almost zero. In those areas, midwives are almost always available (ibid.).

15.3.3 Gynaecologists

In 1997 there were 613 gynaecologists working in Dutch hospitals. In general, they work in general hospitals.

15.3.4 Organised maternity care

99% of maternity nurses are female. The intake of first-year students has decreased by almost 12%, the total number of students has increased by 17%. As a result, the number of qualified maternity nurses that enter the labour market on an annual basis, dropped from 149 in 1993 to 51 in 1997 (Welling et al. 1999).



The commencement of a shorter course solved this problem, leading to a considerable number of new students. In 1998, 395 students completed the course and in 1999, 260 students graduated (VWS 2000).

15.4 Financing and income

15.4.1 General insurance system

In the Netherlands, the 'Bismarck' model is used. The financing of this system takes place via social insurance and is managed by legally set up private organisations, that have agreements with health care services on services and financing (Rutten & Van Doorslaer 1999).

The Netherlands has a dual insurance system. There is a public system for people below a certain level of income. These are mainly employees and 'small' self-employed persons, but also the ones claiming social security (including the elderly). This form of insurance is compulsory as laid down by the Sickness Fund Act (ZFW). In the Netherlands, approximately 61% of the population is compulsorily insured by a sickness fund.

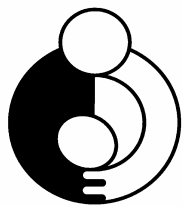
Then there is a private system, for those who do not qualify for the ZFW. They arrange contracts with a private insurer themselves. Furthermore, there is an insurance for everyone, the Exceptional Medical Expenses Act (AWBZ), for such things as nursing homes, or institutions for handicapped persons. The AWBZ is compulsory, but employers pay the premiums for their employees (Boerma et al 1993; Van Kemenade 1997).

Health care in the Netherlands is financed through premiums paid by insured people. Most of the time, the employer also pays a part.

15.4.2 Contracts

Insurance companies arrange contracts with midwives. The role of the insurer is changing more and more into an active purchasing agent for care. Midwives need to negotiate more and more about the establishment where they work, implementation of work and salaries.

Insurers judge whether there is a need for midwives or not in a certain area. They also check to see if the midwife meets basic quality standards. Often the midwife and the insurer make agreements about the quality of care that the midwife has to deliver. This involves such things as the design of the practice, access, support (relief 24 hours a day, seven days a week) and the hospitals where women can be referred to. Insurers can refuse midwives if they want to. This way they can control the supply and demand in midwifery care. The Dutch 'Mededingingsautoriteit' (authority that



regulates competition)(NMa) forbids agreements concerning the establishment. According to this authority, there cannot be any agreements made that will decrease the opportunities for competition. The primate that protects the midwives (see 4.3) is therefore in conflict with the rules of the NMa and European legislation.

15.4.3 Reimbursement

The costs of midwifery care are financed through health insurance. Midwifery care is free of charge and maternity care is partially reimbursed. This is applicable under certain conditions. If a normal pregnancy and birth is expected, the woman is obliged to be assisted by a midwife. Only in areas where no midwife is available, do sickness funds reimburse midwifery costs for a general practitioner or a hospital. This is called the primate of midwifery (Welling et al. 1999). The court has decided that the primate as from January 1st 1999 should be lifted, but the State and the KNOV have appealed against this. Some insurers have already deviated from the primate, even though there has not been a verdict yet.

Privately insured clients can choose between a midwife or a general practitioner. Private insurers often reimburse the costs of a polyclinical delivery. Socially insured clients have to pay the extra costs of a polyclinical delivery without medical problems, themselves.

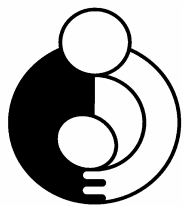
Gynaecological care is the most expensive. In the case of a normal pregnancy and birth, these costs are not reimbursed. Only if there are complications will the insurer reimburse the costs a specialist (Hessing-Wagner 1991).

Socially insured clients have to pay out-of-pocket payments. The remaining costs of up to a maximum of eight days of care are reimbursed by the sickness funds (Welling et al. 1999). If the maternity centre cannot supply the care, the insured can get a substitute payment (budget). A lot of private insurers give their insured client a free choice between a budget and a reimbursement (De Boer 1994). Socially insured clients do not have this choice.

15.4.4 Income

In 1999, midwives with independent free practices were expected to conduct an average of 125 deliveries, including 'durante partu' referred clients.

This average was far below the norm, which was 150 deliveries in that year. In the year 2000 the Minister of the Health Department took some measures. The norm has now been reduced from 150 to 120 deliveries. This means that a midwife can now earn her income performing 120 deliveries a year. Negotiations about a further reduction of the norm still continue. The insurer pays the midwife €677 per delivery.



Having paid 'practice-costs' and taxes, this leaves an independent midwife an annual net income of about €30,151.

The tariffs in midwifery care, are fixed by the College Tariffs Health Care (CTG) according to the Law Tariffs Health Care (WTG).

15.5 Training

15.5.1 Admission requirements

To be admitted to a midwifery course, students need a high school diploma including biology and science. They also need to be in good health (Crébas 1992).

Because there are more applications than places, there are numerous clauses for all four midwifery schools (the first selection). The second selection procedure consists of an interview between the candidate and 210 people.

15.5.2 Colleges

At the end of the course, the student must have realised a lot of goals, concerning the following areas (Schoon 1998):

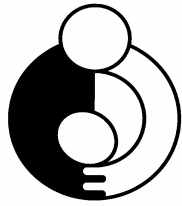
- Actual midwifery activities
- Prevention
- Guidance/ communication
- Managing a practice
- Increasing and maintaining professional skills.

The following practicals have to be done: antenatal care (29 weeks), natal care (26 weeks), postnatal care (14 weeks), ultra-sound scan/ antenatal diagnostics (4 weeks), incubator ward experience (3 weeks), gynaecological ward experience (3 weeks), and pregnancy education (2 weeks).

The student must have performed a minimum of 40 deliveries in primary care and 20 deliveries in secondary care. Not only is the number of deliveries fixed but also the minimal number of activities in antenatal, natal and postnatal care (Schoon 1998).

15.6 Developments

There are a lot of developments in midwifery care at the moment. Those developments will lead to opportunities as well as threats.



15.6.1 Threats

The professional group of midwives indicates that there is a serious shortage of midwives. Some midwifery practices have to close down because there is no adequate substitution or replacement. Furthermore, there is increasing pressure of work, early resignation of midwives and a stagnation of influx of new midwives (SMV 2000).

There is also a concentration of hospitals. This implies that the number of places where secondary care is provided, is decreasing. This could result in secondary care not being easily accessible anymore by primary care. If this happens, home deliveries could be in danger (Smulders 2000).

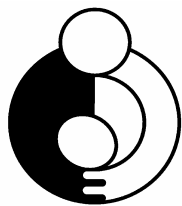
Another problem could be the developments in the capacity of both general practitioners active in midwifery and organised maternity care. The stopping of general practitioners with midwifery and the shortage of maternity nurses will increase the pressure of work for midwives. This could affect the quality of care.

15.6.2 Opportunities

There are possibilities for midwives to improve their position and to improve midwifery care. Co-operation between midwives themselves and between midwives and other professional groups could lead to a better redistribution of tasks. Then midwives would get more time for essential tasks and so they could spend more time on each client. However, this co-operation and the development of 'big' (multidisciplinary) group-practices could also lead to more stable working hours and shift work for midwives.

District offices (which are being developed) could support practices with not only quality, and professionalism, but also with purchasing, administration and other organisational activities. Midwives will then be relieved of non-client based activities. In this way, the imbalance between work and a private life could be dealt with.

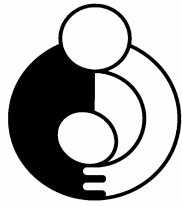
15.7 Statistics



Year	1999	2000
Inhabitants		16,000,000
Birth rate	200,445*	
Born alive		
Stillborn		
Perinatal mortality rate		0.79%
Midwives		1,578
Births per midwife		120-130
Gynaecologists	>613	
General practitioners active in midwifery care	1,120	

The perinatal mortality is: the number of deaths and stillborn from week 24 of the pregnancy until 28 days after the delivery.

*CBS 2000



16. Midwifery in Portugal

16.1 The midwife

16.1.1 Tasks and responsibilities

In Portugal, midwifery is a medical-technical profession, which provides specific care, education, counselling and family support. Midwives' work is specifically geared towards meeting the emotional, physical and social needs of the client. They also have the capacity to identify gynaecological problems. In short, the tasks of a midwife include:

1. Counselling (attn. conception, fertility, adolescence)
2. Antenatal check-ups
3. Preparation for different stages of labour
4. Normal delivery (incl. analgesia, perineal repair)
5. Postnatal care
6. Parental education (e.g. breastfeeding)
7. Family planning.

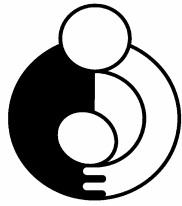
Formally, the gynaecologist is always responsible for the midwifery care provided to pregnant women. But in practice, a midwife is partially able to take responsibility for a normal pregnancy and birth independently. In fact, midwives conduct the actual delivery process in about 50% of normal cases. If there are abnormalities, the gynaecologist takes over.

The Portuguese profession of midwives is not protected by law. Nor are their tasks and responsibilities. But they will be protected in the near future, due to a law with a detailed job specification being developed right now.

16.1.2 History

There have been a lot of historical developments in the twentieth century, that have influenced the Portuguese midwifery system.

In 1974 the political system changed to a democracy. Nursing careers changed after the introduction of a basic law on the educational system in 1986. Expert nurses were introduced in the law of 1991, which was revised in 1997 by the Technical University System. Since then, midwives have had to have a degree in nursing.



Furthermore, they get access to the most efficient and technical up-to-date methodologies. This has contributed to the fact that childbirth is now highly 'medicalised', and that the current practice is to use specific instruments. This is also due to the hospital being the place of birth, while before the 1970s, deliveries took place at home.

Maternity clinics with less than 500 deliveries were closed during the 1980s. The consequence of this was a drastic reduction of perinatal and maternal mortality.

16.2 The midwifery system

Several professional groups are active in midwifery care. In addition to the midwife and the gynaecologist, the general practitioner, the paediatrician and the nurse take part in antenatal, natal and/or postnatal care.

16.2.1 View on pregnancy and birth

While the prevailing view on pregnancy and birth among midwives is natural, these are highly 'medicalised' processes in Portugal. This is expressed in some features of the Portuguese midwifery system.

16.2.2 Division of tasks

When a woman finds out she is pregnant, she goes to a midwife either in a hospital or in a health centre. She can also ask to see a (private) gynaecologist. Midwives and gynaecologists recognise each other's role in midwifery care. Therefore, they can co-operate with each other without feeling competitive. Each professional knows what to do in each phase of the pregnancy and birth and is responsible for his or her own actions.

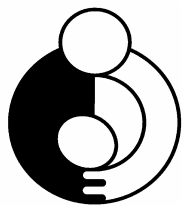
All deliveries should take place under the responsibility of a gynaecologist. However, half the number of deliveries are actually conducted by midwives.

16.2.3 Place of birth

There is a law that determines that the delivery has to take place in a 'hospital-environment', with the result that almost all deliveries take place in hospital. Home births occur only by accident. Gynaecologists usually influence the decision of the parents to deliver their baby in a private maternity clinic.

16.3 Number of professionals

In this paragraph the number of midwives, gynaecologists and other professionals active in midwifery care are discussed.



16.3.1 Midwives

Of the 1,600 registered midwives in Portugal in 2000, 1,100 actively practiced midwifery. This means an estimated number of two midwives per 1,000 fertile women. Most of the midwives are female (1,550). The mean age averages 45 to 50 years old.

All midwives are employed in the public sector (hospitals) and the majority of midwives have a second job in the private sector (maternity clinics). Due to the excessive demand of midwives, they work about 70 hours per week.

16.3.2 Gynaecologists

There is no official registration of the number of gynaecologists. The Portuguese Association of Midwives estimates this number to be at 700.

16.3.3 Others

There is no official data available on the number of general practitioners or paediatricians who are active in midwifery care. In 1998, there were 37,747 nurses in Portugal (3.8 per 1000 inhabitants). It is not clear, however, how many of these were active in midwifery care.

16.4 Financing and income

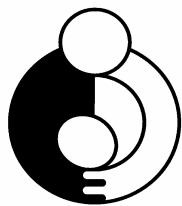
16.4.1 Finance system

The organisation of health services is based on the key idea that the state is the provider, the employer and the financing agency of health care. The Portuguese health care system is characterised by three co-existing systems of health care coverage: the National Health Service (NHS), special insurance schemes for certain professions, and voluntary private health insurance schemes (European Observatory 2000).

The Ministry of Health is divided into four directorates: one for hospitals, one for primary care, one for pharmaceuticals and one for safety and occupational health.

At a district level, regional health administrations or authorities (ARS) maintain responsibility for the integration of services with the private sector and for the location and administration of health centres (Van Kemenade 1997).

Portugal has an NHS (Servico Nacional de Saude: SNS), which is the responsibility of the government and covers the whole population. The scheme provides old age and disability pensions, cash sickness and maternity benefits, health cover, unemployment benefits and family allowances (ibid.).



There is a complete network of primary care services, which is managed by district officers. They are responsible for the population they serve and there is no internal competition in the public sector. Primary care services make use of the private sector's diagnostic services. The services are reimbursed through pre-established prices. Total expenditure on the public health service is nationally determined and governed (ibid.).

There is a significant private sector in both ambulatory and hospital care.

The SNS is financed predominantly through taxation, but also partly through contributions from users. About 10% of the population has private insurance.

16.4.2 Benefit packages

The benefit package of the national health scheme consists of general practitioner visits, pharmaceuticals, diagnostics, hospital care, preventive care and some dental care. Care for the chronically ill and the elderly is the responsibility of the family. The use of co-payments has increased over the last few years and has been imposed on several services. If the private sector is used in certain situations, the patient pays the total bill outright and gets partially reimbursed by the SNS later (Van Kemenade 1997).

With regard to midwifery care, parents are entitled to all medical care, nursing care and parenthood allowances (Dialoog met de burgers 2001).

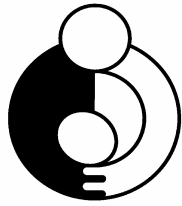
16.4.3 Income

All midwives are paid a salary when employed in a hospital. The public sector has a salary gradation system with of eight grades that vary from a basic salary of €18,000 to a maximum salary of €31,000 based on a 35-hour working week. A midwife earns a fee for each service she performs, after normal service hours in the private sector. This entails, for example, €400 for a delivery.

16.5 Training

16.5.1 Admission requirements

In order to be admitted to a midwifery course, a student must possess a degree in nursing. Besides that, two years of working experience as a professional nurse is required.



16.5.2 Colleges

The training course takes another four semesters after a 4-year nursing course. Examples of subjects that are dealt with during the course, are:

- Anatomy
- Physiology
- Normal pregnancy and birth
- Recognition of abnormalities.

A student has to complete 1,050 hours of theoretical education and 1,350 hours of practical training before graduation. The practical training includes all facets of pregnancy and birth: from health promotion to the delivery process; from perineal repair to postnatal care.

About one hundred students follow the Technical University Education, regulated by the government.

16.6 Developments

The Portuguese Association for Midwives is trying to expand midwives' autonomy and competencies and to extend their professional work to all the areas where they think it is needed. By doing this, they encounter some threats as well as opportunities.

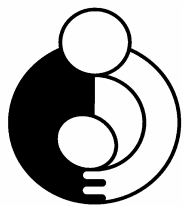
16.6.1 Threats

There is a heavy workload for midwives in Portugal; they have double jobs in both the public hospitals and the private maternity clinics. This is because midwives are in great demand. Moreover, the average age among midwives is high. So, the shortage of midwives is getting worse and work pressure is ever increasing.

Midwifery care is highly 'medicalised'. Births mainly take place in hospital and midwives are used to using specific instruments. Midwives do not have the authority to decide on the guidance needed and the allocation of resources. These are all threats to the goals set by the Association.

16.6.2 Opportunities

A first step in the improvement of the position of Portuguese midwives will be the new law on tasks and responsibilities. The new regulation and full transposition of the EU-directives will change the situation in the near future. The already existing



relational competence with other professionals plus their technical competence and knowledge will help the midwives to improve the culture of co-operation and communication. Within this culture, one should be able to define the midwives' capabilities.

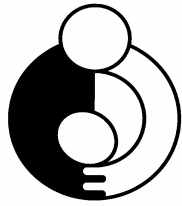
If this goal is accomplished, the Association predicts positive consequences for midwives, since they will obtain:

1. Full capacity and responsibility in the vigilance of normal pregnancy
2. Full responsibility for a normal delivery
3. More influence on the normal functioning of health care institutions.

16.7 Statistics

Year	1999	2000
Inhabitants		9,800,000
Births	116,691	
Born alive	116,038 (99.4%)	
Stillborn	653 (0.6%)	
Perinatal mortality rate	0.56%	
Midwives		1100 (1600 registered)
Births per midwife		53
Gynaecologists		ca 700
General practitioners active in midwifery care		

Definition of perinatal mortality: The number of babies born dead after 28 weeks of pregnancy plus babies who die in their first week of life.



17. Midwifery in Spain

The 17 regions in Spain all have a lot of autonomy with regard to their health care policy. Therefore, there can be many differences between the regions. This chapter describes the main features of the national midwifery system. Because of the regional differences, the results in this chapter might not give a true picture of all the regions in Spain¹.

17.1 The midwife

17.1.1 Tasks and responsibilities

Since 1960, a law has regulated the professional competencies of Spanish midwives. The European Union *Midwives Directive 80/155/EEC* applies to Spain too.

In short, the duties of Spanish midwives are:

1. Parental education
2. Antenatal care and follow-up of a normal pregnancy
3. To share the care of a high-risk pregnancy with the gynaecologist
4. To care for and to assist the woman during labour and to conduct normal deliveries
5. To care for the new-born baby in the delivery room
6. Postnatal care at home, or in community clinics
7. To conduct breastfeeding groups, family planning, sex education, and menopause education.

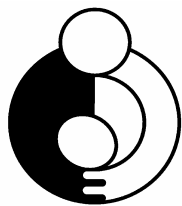
A midwife is able to take responsibility for a normal pregnancy and birth independently. If there is an abnormal pregnancy or birth, the gynaecologist is ultimately responsible.

17.1.2 History

From 1950 until 1958 births took place at home; midwives were fully responsible for the mother and baby.

1. _____

¹ There has not been a final check of the description of the Spanish midwifery system (Chapter 17).



After 1958 births took place in maternity hospitals. Care for the woman has since then been shared by midwives and obstetricians.

Since 1980 midwives have been much more involved in the reproductive aspects of the woman's health. They are involved in family planning, sexually transmitted diseases and the menopause.

In 1994 a new midwifery-training curriculum started. This prepares the midwife to be responsible for the care of the woman during the maternity process. The new training course also prepares the midwife for working in hospitals and community settings. Teaching methodology and research is also included now.

17.2 The midwifery system

In the midwifery system in Spain, several professional groups are active. In antenatal care, midwives, gynaecologists and general practitioners participate. Either a midwife or a gynaecologist provides natal care and in postnatal care, paediatricians and nurses are also involved.

17.2.1 View on pregnancy and birth

In Spain, the prevailing view on pregnancy and birth is physiological. Both midwives and society consider those processes to be natural. This is not always reflected in all features of the midwifery system (see also paragraph 6.1).

17.2.2 Division of tasks

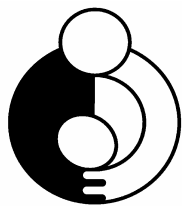
If a woman thinks she is pregnant, she can go to a general practitioner, who will refer the woman to the midwife. The woman can also go directly to a midwife at the Primary Health Care Centre.

If the pregnancy is abnormal, the woman will be referred to the gynaecologist.

If the pregnancy is normal, the midwife does the antenatal care and refers the woman to the gynaecologist three times (three visits). If the pregnancy is abnormal, the obstetrician does the antenatal care (more often than not in the hospital) and the midwife deals with health education.

17.2.3 Place of birth

Most births take place in hospital. Less than 1% of all births take place at home. The health insurer does not reimburse the home delivery. Childbirth can also take place at a birth centre. There are four birth centres now in Spain, and this number is increasing.



Midwives, gynaecologists and parents decide together where the delivery is going to take place. But because home deliveries are not reimbursed, this is not really an option.

17.3 Number of professionals

In this paragraph the number of midwives, gynaecologists and general practitioners will be discussed.

17.3.1 Midwives

In 2000, there were approximately 5,000 midwives in Spain. Most of them (90%) are employed in the public sector and work in hospitals. The other midwives work in the private sector. Less than 1% work in independent free practices. Most midwives are between the age of 36 and 65 years old. There is a shortage of younger midwives, because there was a period of nine years without any midwifery-training.

17.3.2 Gynaecologists

In 2000 there were about 5,000 gynaecologists in Spain.

17.3.3 General practitioners

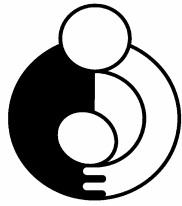
There are no official figures about the number of general practitioners actively involved in midwifery care. The figures vary depending on the region. But the general practitioners are involved in antenatal care.

17.4 Financing and income

17.4.1 General insurance system

There were two historical periods in the Spanish health service. The first (1942-1977) covered the Franco regime, with the growing importance of the social security model. The second (1978-1991) was characterised by health reforms of the 1986 enactment of the 'Ley General de Sanidad' (General Health Law). The ultimate goal of the Health Law was to form the basis for future developments in the National Health Service, which would cover the entire population and would include the whole range of health services. Thus, Spain provides compulsory health insurance for the entire population, including 5% of the population covered by a public servants' scheme and 0.9% covered by social benefits. Those excluded are mainly the wealthy and illegal immigrants (Van Kemenade 1997).

Spain is divided into 17 regions, which all have a considerable degree of autonomy. The National Health Service has been highly decentralised, including health



competence in seven of the autonomous communities. The National Health Service has been formed by the overall health service of the central administration, which operates through INSALUD (Instituto Nacional de la Salud), and the autonomous regions, which operate their own Regional Health Services. The administrative functions of the INSALUD have been decentralised to the autonomous regions (CC.AA). The regions are responsible for health care in their area (ibid.).

A few regions have population-based budgets. Most regions have more risk-adjusted budgets. Two regions have a totally different finance system. They collect taxes themselves and have more money to spend.

Health care is mainly publicly financed (79%). The remaining 21% is mostly financed directly by patients but also through private insurance schemes. The Spanish health care system is dominated by a compulsory national health system (79%), funded by a mix of general taxation (62%) and social insurance contributions (17%) (ibid.).

According to the 1997 National Health Survey, up to 8.9% of the Spanish population had private health coverage through voluntary insurance in 1997, although survey data probably tends to underestimate this number. Available data on private expenditure suffered from a number of problems (European Observatory 2000).

Private insurance companies have the freedom to fix prices and premiums and each insured person pays only for his/her own risk. About 99% of the population have only public insurance, 10% have private insurance in addition to that provided by the state, and 1% have only private insurance (Van Kemenade 1997).

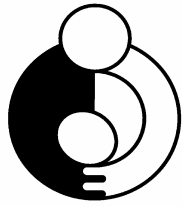
17.4.2 Reimbursement

The following midwifery care is reimbursed: medical care during the pregnancy plus medical care during and after the delivery, and in the case of pathology, hospital admittance to a social security centre or to another approved centre (Dialoog met de Burgers 2001).

17.4.3 Income

Midwives are either paid a salary for employment or paid per client or paid a fee-for-service. If the midwife works at the hospital, she is paid a salary. Her income is set by trade unions. If the midwife works in the private sector, she is paid per client or fee for service. Then her income is set by midwifery associations and the nursing college.

Midwives estimate their average income annually at about €21,868.



17.5 Training

17.5.1 Admission requirements

To enrol on the course, students need to have completed a 3 year nursing university course. Next year, this course will be shortened by one year. Candidates also need to take the Spanish National Exam, because there are 5,000 candidates to cover 150 places for midwifery students.

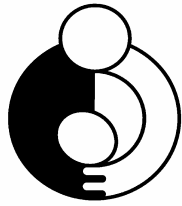
17.5.2 Colleges

The training to become a midwife takes 2 years. Students have to complete 1,100 hours of theoretical education and 2,500 hours practical experience. Practical training includes more than 100 antenatal examinations, more than 100 births, postnatal home visits and parenting classes. Students are also educated about sexually transmitted diseases, cancer prevention and the menopause.

During the training course, students study subjects like:

- Maternity care (normal and abnormal)
- Neonatology
- Parental education
- Gynaecology
- Epidemiology
- Demography
- Anthropology
- Health education
- Legislation
- Research.

Students get paid during their training. The government pays for the course, so the government also determines where to invest the money. However, both hospitals and universities are responsible for the course.



17.6 Developments

The purpose of the 'Associacio Catalana Llevadores' is to promote pregnancy and birth as physiological processes. In order to achieve this, the Association wants to promote women's health and to co-operate with women's groups. Midwives also need to work together with gynaecologists, family doctors and nurses. The Association aims to make developments in continuing education and in more evidence based midwifery care. By means of these kinds of actions, the Association expects to be able to protect the midwives' position at a governmental level. However, they have to resist some threats.

17.6.1 Threats

Women in Spain do not have a lot of options related to the place of birth, according to the Association. Because home deliveries are not reimbursed by the social security, parents are discouraged to choose for a home birth. Women need to be more actively involved in decision-making during their pregnancy and delivery.

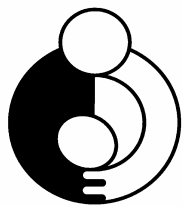
Faced with the fact that the number of Caesarean section and forceps deliveries is high, we can conclude that childbirth is 'medicalised'. There are only a few hospitals that make it possible for normal births to take place in normal surroundings (similar to home).

There are just as many gynaecologists as there are midwives. This can cause competition between the two professional groups. Sometimes, gynaecologists do not refer a normal pregnant woman to a midwife.

17.6.2 Opportunities

According to the Association of Midwives, the low perinatal and maternal mortality rates are positive aspects of the Spanish obstetric system. Moreover, the public finance system covers the costs of all women giving birth in hospitals and getting antenatal care at health centres.

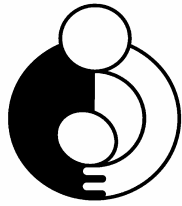
Midwives promote preventive aspects of pregnancy, birth, postpartum and breastfeeding. What midwives need to do now, is to promote physiological (normal) births even more. They should create opportunities to counter the threats and to actually achieve their goals.



17.7 Statistics

Year	1999	2000
Inhabitants		39,600,000
Birth rate	377,809	
Born alive		
Stillborn		
Perinatal mortality rate	0.64%	
Midwives		± 5,000
Births per midwife		
Gynaecologists		± 5,000
General practitioners active in midwifery care		

According to the umbrella organisation the perinatal mortality rate is the number of stillbirths and early neonatal deaths per 1000 total births.



18. Midwifery in Sweden

18.1 The midwife

18.1.1 Tasks and responsibilities

Traditionally, midwives in Sweden have had a strong and autonomous role in the interface of reproductive health and public health. In the primary health care system today, the domain of the Swedish midwife includes obstetrical and gynaecological care of the woman throughout her reproductive life cycle (Wildmark et al. 1998).

According to national guidelines there are five main areas of practice for the midwife in primary health care (ibid.):

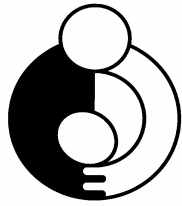
1. Antenatal care
2. Parental education
3. Family planning (i.e. contraceptive counselling and prescriptions to women and teenagers)
4. Health information and education
5. Taking Papanicolaou smears in cervical cancer screening programmes.

The national guidelines do not encompass all midwives' duties, however, for a midwife is also responsible for care in a normal pregnancy during the antenatal phase. The midwife is able to identify abnormalities and to refer women directly to gynaecologists when she deems it necessary, without first consulting another physician.

In the natal phase, the midwife is accountable for certain tests, examinations, treatments and normal delivery. During delivery the midwife assists the woman, monitors everything and, if necessary, she performs the delivery operation with her hands and using obstetrical forceps or a vacuum-cap. A midwife also participates in examinations and treatments provided by doctors.

In the postnatal phase, the Swedish midwife is responsible for the care of new parents and newborn babies in the maternity ward or at home.

A midwife is also accountable for the care of expectant and post-natal mothers, newborn babies and also female patients with both commonly occurring and complicated disorders that are treated within obstetrical and gynaecological care.



The Health and Medical Services Act and The Act on Professional Obligations govern the midwife's duties. On the basis of these acts, a midwife must be able to initiate and carry out measures aimed at improving health and preventing the occurrence of illness; always with an ethical approach and in accordance with scientific development and reliable experience within the midwife's speciality. In her professional capacity, the midwife must follow and be able to apply the *statutes, administrative provisions and other rules* that are relevant (Swedish Board of Health and Welfare).

18.1.2 History

The profession of midwives has been protected by law since 1711 (Stockholm) and 1777 (Sweden). From 1998 onwards, midwives have been legally recognised in the Law on Professionals in Health Care. A 'Description of Required Competence' from 1995 reflects the general recommendations made by the Swedish Board of Health and Welfare with regard to the functions and activities of midwives.

Midwives have been responsible for their own work at a community level since early 1700, supervised by medical authorities. Around 1900 all municipalities were obliged to employ a midwife. They had the right (from 1832) to use instruments such as forceps and cranioclast. From 1910 to 1920 paediatric nurses were made responsible for the care of infants older than ten days. From 1952 onwards, students had to be registered nurses to be admitted to midwifery school. And since the 1970s, midwives have been engaged in fertility regulations and have been given the right to prescribe contraceptives. Since this time, nursing and midwifery-training have been offered at university level.

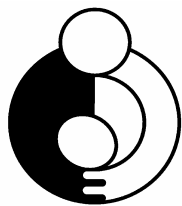
18.2 The midwifery system

18.2.1 Views on pregnancy and birth

In Sweden there is a natural approach to childbirth, yet with the constant presence of a highly technological medical system at hand. This is reflected in some aspects of the Swedish midwifery system.

Almost all women give birth in hospitals, and are routinely attended by nurse-midwives. But an anaesthesiologist, a gynaecologist and a paediatrician are available for about 95% of all births.

Sweden's Caesarean section rate rose to 13.4% in 1998. The increased rate can mainly be explained by a higher rate of nulliparas and deviations from clinical guidelines; that is, the operations were not in accordance with evidence based medicine. (Researchers have attributed this to the requests of women themselves who are fearful of vaginal births for various reasons).



The vast majority of Swedish women receive pain medication when in labour. They are encouraged to give birth in a position they find comfortable and they only rarely lie on their backs to give birth (Devries et al 2001).

18.2.2 Division of tasks

Midwives provide most of the midwifery care. For women with normal pregnancies, sometimes two visits to a physician are arranged too. One early on in the pregnancy, to do an ultrasound test and to determine the time of delivery, and one nearer to the time of delivery. Most of the time, the woman visits the gynaecologist only if her pregnancy shows signs of complications, or if she requests it. If there are abnormalities, the gynaecologist conducts the delivery.

In Sweden, the professional who sees the pregnant woman prenatally is not the same as the one who sees her during the delivery. This is partly because the prenatal clinics and the birthing hospital centres are spatially and administratively separate from one another. It may also be influenced by the fact that Swedish midwives are not expected to be available at any time of day or night to help a woman in labour (Devries et al. 2001).

Although midwives handle all normal deliveries, physicians frequently play a role. In the year 2000, 75% of all deliveries took place under the responsibility of a midwife and 12% were conducted by gynaecologists. The other 13% were conducted in co-operation with a midwife and a gynaecologist.

18.2.3 Place of birth

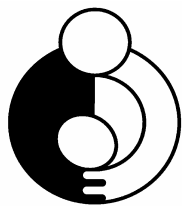
Almost all births in Sweden take place in hospital maternity care centres. Home births in Sweden are rare. A midwife almost always attends the few women who *do* choose to have a home birth. Parents are in fact free to choose the place of birth. However, political decisions also play a determining role.

18.3 Number of professionals

In this paragraph the number of midwives, gynaecologists and other professionals active in midwifery care will be discussed.

18.3.1 Midwives

In the year 2000, approximately 7,100 midwives were active in Sweden of which 99% worked in the public sector. About 50 midwives are male. The average age among midwives is 47 years old.



In addition to working in obstetric and gynaecological divisions of hospitals, many midwives in Sweden work in 'antenatal health care centres', run by the county councils. These centres are located in the community and are mainly staffed by midwives, with access to physicians on a regular basis. The ANHCs have traditionally been named to reflect their primary function as antenatal clinics. But they also provide contraceptive counselling, run adolescent clinics and take part in cervical cancer screening (Wildmark et al 1998).

One percent of the midwives are employed in the private sector. Private clinics perceive a need for more personal care, a softer approach, and more convenient opening hours. But they do not differ significantly from government clinics. These private clinics are also covered by national health insurance (Devries et al 2001).

There are only about fifteen midwives in Sweden who work independently in their leisure-time.

18.3.2 Gynaecologists

There were 1,803 gynaecologists in Sweden in 2000. They play an important role in midwifery care, especially in difficult cases (Epidemiologiskt Centrum, Socialstyrelsen Stockholm).

18.3.3 Others

Very few general practitioners are active in midwifery care. Some practise midwifery only in extremely rural areas, due to a lack of gynaecologists there.

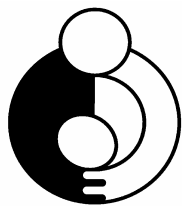
In community based health care centres, paediatric nurses are involved in the postnatal care of women and newborn babies.

18.4 Financing and income

18.4.1 Finance system

The Swedish national government is divided into two ministries and authorities/boards. The ministries are primarily responsible for matters of policy. The boards are in charge of implementing public policy according to current legal legislation and regulations.

The Ministry of Health and Social Affairs (Socialdepartementet) deals with policy matters and legislation concerning items such as the social insurance system, health and medical care, social services and family policy. The National Board of Health and Welfare (Socialstyrelsen) is the government's central advisory and supervisory agency in the field of health services (Van Kemenade 1997).



Sweden has a nationally organised system of health care for the whole population. The system is organised at county council level: there are 23 county councils and 3 large local authorities. The councils are responsible for the administration, financing and delivery of care, both as an inpatient and ambulatory patient (ibid.).

The counties also operate a public dental service and services for the mentally ill. They are organised into the Federation of County Councils which negotiates with the government on political and economic issues, and with the trade unions regarding salaries and working conditions of health care personnel.

The sources of revenue for health care are: taxation, including mainly proportional income taxes as well as indirect taxes, the national insurance system, private expenditures, i.e. out-of-pocket-payments and private insurance (Van Kemenade 1997).

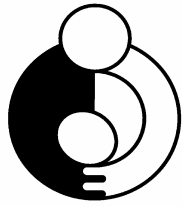
The major part of the costs of health care is financed by income tax levied by each of the 26 counties on their population (75%), like a universal public health insurance. Other incomes for the counties are grants and payments for certain services from the government, making up a total of 12%. The remaining 13% constitutes private expenditure. The redistribution between the national government social insurance system and the counties is of two types: the transfer of resources and the reimbursement of providers (ibid.).

The social insurance system is centralised at a national level. Insurance is compulsory. The main part of social insurance is financed by employers (80%), and the rest through transfer payments by central government (ibid.).

18.4.2 Benefit packages and co-payments

All citizens are entitled to a benefit package and caring services. Besides primary care and inpatient care, preventive care and dental care are also covered by the national health insurance. Costs of health care are paid directly by the county councils in-natura system, excluding the care for which an individual payment is required (Van Kemenade 1997).

Parents are entitled to full care, concerning pregnancy and birth. This consists of regular prenatal check-ups, childbirth in a hospital and postnatal care including home visits. Working women have a right to paid sick leave before a child is born if the pregnancy is difficult and up to one year's parental leave after childbirth at 80 percent of their salary (Devries et al 2001; Dialoog met de burgers 2001).



18.4.3 Income

Around 1900, midwives earned a small guaranteed income, part of it consisting of food, if desired. The midwife could only charge families, if they could afford to pay. At hospitals, midwives later became employees with fixed salaries. These salaries are set by negotiations between trade unions and the employers.

Nowadays, the average income for the normal working midwife is approximately €2,183 per month (i.e. €26,196 annually). In big cities, the midwives earn more money than midwives do in smaller towns.

18.5 Training

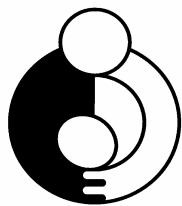
18.5.1 Admission requirements

Midwives in Sweden must be registered nurses prior to becoming midwives. Following completion of a 3-year nursing degree at university level and at least 6 months working experience as a nurse, an additional 1½-year midwifery educational course must be completed to qualify for a licence as a midwife (Wildmark et al 1998). Therefore, a midwife in Sweden is also called a nurse-midwife.

18.5.2 Colleges

In midwifery education, the main subject area is reproductive health within a life cycle perspective. This includes both obstetric and gynaecological knowledge (Wildmark et al 1998). Some of the subjects dealt with during the course are:

- Parental education
- Care and supervision of a normal pregnancy
- Delivery
- Identification of abnormal conditions during the three phases (incl. the care they must provide in the case of abnormalities)
- Breastfeeding advice
- Regulation of sexuality and fertility
- Counselling advice on sexual matters.



There are 200 to 250 students who study midwifery on an annual basis. Before graduation they must have completed approximately 10 weeks of antenatal, 15 weeks of natal and 5 weeks of postnatal practical training.

The government is responsible for the training course and has set some general goals in the 'Higher Education Act'. But decisions concerning admission and curriculum are left to each College/ University itself.

18.6 Developments

In the current situation there are many developments. As a result, new opportunities and threats arise.

18.6.1 Threats

According to the Swedish Midwife's Association, there is a danger of 'medicalisation'. This stands in the way of a more physiological and more natural approach to childbirth.

A financial cut-back within the health care system is threatening the current midwifery system. It also constitutes an obstacle to new midwives' initiatives.

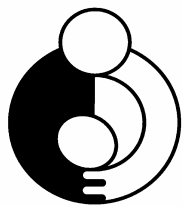
Another negative point, especially for women, is the poor continuity of caregivers. The practitioner who sees the pregnant woman prenatally is not the same as the one who sees her during delivery.

18.6.2 Opportunities

There is a common consensus among health care professionals that pregnancy and birth are normal processes and not a disease. Moreover, it is said that good midwifery is fundamental to achieving good public health. Midwifery can prevent unnecessary medicalisation.

Two large maternal clinics (2000 deliveries each year) are being launched in Stockholm at the end of this year. They will be managed by a head-midwife and only healthy expectant mothers will be admitted. Gynaecologists will work as consultants and only participate when they are called for. This way of organising midwifery care will have a national and favourable impact on the position of midwives in Sweden.

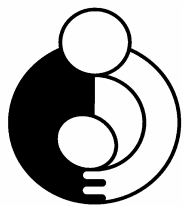
Women's influences and their free choices must be strengthened in order to achieve success in these kinds of initiatives, and to achieve good public health. Research on evidence-based care will also serve these goals.



18.7 Statistics

Year	1999	2000
Inhabitants		8,882,792
Births	88,512	90,713
Born alive	88,173 (99.6%)	90,441 (99.7%)
Stillborn	339 (0.4%)	272 (0.3%)
Perinatal mortality rate	0.56%	0.32%
Midwives		7,100 registered
Births per midwife		
Gynaecologists		1,803
General practitioners active in midwifery care		Few

Definition of perinatal mortality: death of child after 28 weeks of gestation, within 28 days of birth.



19. Midwifery in the United Kingdom

19.1 The midwife

19.1.1 Tasks and responsibilities

The UKCC document “Midwives Rules and Code of Practice” (1998) makes full reference to the ICM/FIGO/WHO agreed definition of a midwife (1992) and the activities of a midwife as laid down in 80/155/EEC Article 4.

In the UK, a midwife is able to take responsibility of a woman experiencing normal pregnancy and birth independently. In addition, a midwife is always present at a birth even if there are problems. In cases of abnormality she will contact a gynaecologist (who, in the UK is known as an obstetrician), who will then be responsible for the management of the case. The responsibilities of the midwife and the registered medical practitioner are inter-related and complementary and each practitioner is accountable for his/her own practice.

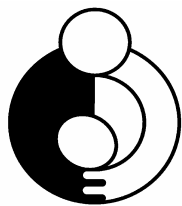
The profession of midwifery has been protected in law since the Midwives Act of 1902.

19.1.2 History

Since the various *Midwives Acts* dating from 1902, midwifery has been very regulated. In the first half of the 20th century the majority of births were at home ; during the Second World War, women were sent away to give birth in country houses and hospitals and they began to favour institutional natal care.

Following the late return of doctors from the army etc., the power and influence of the medical profession began to grow. From 1960 onwards, there was an accelerated trend towards institutionalised birth and, in 1970, the government took the final step in hospitalising birth, recommending “that sufficient facilities should be provided to allow for 100% hospital delivery. The greater safety of hospital confinement for mother and child justifies this objective” (Campbell & MacFarlane 1987). It was thought that technological developments would make hospital births cheaper and safer (Essed & Zwartsenburg 1996). However, this led to more Cesarean sections etc.

By the mid-1970s there was a growing dissatisfaction about this situation and increasingly militant and vociferous campaigning for better maternity care by both women and midwives. In 1993 the report on *Changing Childbirth* promised a sea of change in maternity care in the United Kingdom. The basic principle of this report was choice, continuity (of care) and control of women, the pregnant woman being the central figure in care, and the midwife being the leading professional for low-risk pregnancies and birth. This policy change originated from the ideas of radical



midwives and feminist user groups who see pregnancy and birth as natural processes and the midwife as an expert in this area. The recommendations of *Changing Childbirth* have been put into practice to varying extents in more than 100 areas (Lee 1998).

19.2 The midwifery system

When a woman thinks she is pregnant, she can go the midwife or a general practitioner in the first instance. If the woman chooses midwifery care, she can stay under the midwife's care until there are problems and the woman has to be referred to the gynaecologist. If she goes to a general practitioner first, he will refer her to the midwife or a gynaecologist. So the gynaecologist can also be the primary care provider of midwifery care, and is not only involved in cases of abnormalities. However there is an increasing trend for gynaecologists to concentrate on the care of women with complications.

Midwives conducted 68.8% of all deliveries in 1999. This is the lowest figure ever. In previous years this percentage was between 70-75%.

19.2.1 View on pregnancy and birth

The midwifery system complies with the general view on pregnancy and birth. Society sees those processes as not only natural, but also as a potential risk. The woman can go to the midwife, as well as the gynaecologist. Midwives see pregnancy and birth as natural processes, but they mainly work in medical environments.

19.2.2 Division of tasks

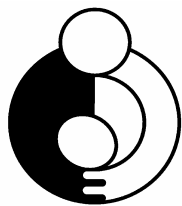
A midwife is always present at a birth, even if there are problems. In the case of a difficult labour, the gynaecologist is ultimately responsible. The midwife continues to care for the woman alongside the gynaecologist.

All general practitioners can diagnose pregnancy. General practitioners who are active in maternity care are mainly involved in the antenatal phase. Very few are involved in natal care or postnatal care.

19.2.3 Place of birth

Parents can choose to give birth in hospital, at home or at a birth centre. However, not all parents receive sufficient information on which to base their decision.

During the 1980s the homebirth rate fell to less than 1%. This was due to medical and government policies, which promoted the hospital as the place for birth, as the use of technology increased.



Between 1987 and 1997 the homebirth rate increased by 1.53% to 2.23% of all births, and is still rising.

19.3 Number of professionals

19.3.1 Midwives

In the United Kingdom 90,378 midwives are registered and 33,291 of them actually practise midwifery. Of the 33,291 midwives, there are 93 male midwives.

In 2000 51% of midwives worked part-time. Less than 1% work in independent practices, 98% work in the public sector and 1-2% work in the private sector. If midwives work in the public sector, they can work in hospitals, birth centres or in the women's homes. The private sector includes private hospitals and independent practices.

19.3.2 Gynaecologists

In 1999 there were 1,153 consultants and a further 924 in training posts under the guidance of these gynaecologists.

19.3.3 General practitioners

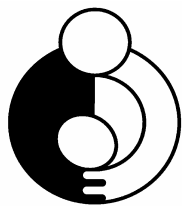
There are general practitioners active in midwifery care, but mostly in the antenatal phase. There is no information about the number of general practitioners involved in maternity care.

19.4 Finance and Income

19.4.1 General insurance system

The National Health Service (NHS) came into operation in 1948 following the provisions of the *NHS Act* of 1946. This Act was of crucial importance in establishing the post-Second World War pattern of health service finance and provision in the United Kingdom. It introduced the principle of collective responsibility by the state for a comprehensive health service, which was to be made available to the entire population to use whenever necessary. Freedom for user charges was a key feature of this approach, which placed heavy emphasis on equality of access (European Observatory 1999).

The NHS is subject to periodic reorganisations. At the apex of its structure is the Department of Health (DOH), headed by the Secretary of State for Health. Each county has its own Department of Health although there are close similarities in terms of broad policy and organisation. Below the DOH are regional health authorities



(RHAs) with broad planning responsibilities. Below the RHAs are more local health authorities, that direct the development of local health care, both hospital and community-based (ibid.).

The NHS is financed mainly through central government general taxation together with some national insurance contributions. In 1986-1997 93.7% of gross spending in the NHS in England was gathered from these sources: 81.5% from the Consolidation Fund, which is general taxation, and 12.2% from national insurance contributions. The remainder of NHS finance (6.3%) was raised through user charges, mainly for pharmaceutical prescriptions and dentistry, and through other miscellaneous sources. Raising finance through general taxation means that there is a broad funding base, covering all forms of income, capital and expenditure taxation.

In addition to general tax-based funding, there was an estimated £ 7,474 million of private expenditure on health care in the United Kingdom in 1996, that constituted 14.6% of the total spending on health care in that year. Less than 11% of the population had some form of private medical insurance (ibid.). In 1996 there were 25 private medical insurers offering coverage in the United Kingdom. Seven of these were non-profit making, provident associations; the remaining 18 may be described as 'commercial insurers', although some of them are mutual societies owned by their members.

Private medical insurance takes two main forms: (employment-based) company insurance and individual insurance. The remainder is made up of voluntary employee-paid groups whereby professional associations or trade unions act as umbrella organisations, but employees meet the costs of the premiums themselves (ibid.).

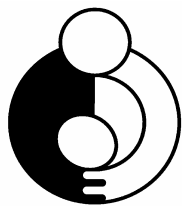
19.4.2 Benefit packages and co-payments

All care provided by the NHS is free. Pregnant women and new mothers are exempt from charges for dentistry and prescribed medicines. Women do not need insurance for midwifery care. But they can enclose insurance policies for luxurious midwifery care.

19.4.3 Income

Midwives are either paid a salary if employed or paid by the client if independent. Salaries are set by negotiations between the health unions and the Department of Health every year, through a Pay Review Body for nursing, midwives, health visitors and professions connected to medicine. Independent midwives set their own fees.

The average income annually for a midwife is about €29,700.



19.5 Training

19.5.1 Admission requirements

The student must be at least 17.5 years on commencing the course and must have the required educational qualifications including a science and either English or Welsh. All courses are university based, and the educational requirements demanded by the universities are higher than the basic professional entry requirements (UKCC 1998).

The total number of students admitted, varies according to the predictions of the Department of Health on staffing needs.

19.5.2 Colleges

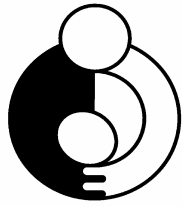
A midwifery-training course is no less than 3 years in duration, and each year consists of 45 programmed weeks. If the student is already registered as a nurse, the course is less than 18 months i.e. 78 programmed weeks (UKCC 1998).

There are 4,500 students accepted annually. They have about 2,500 hours theoretical education and at least 2,500 hours practical experience.

The course enables the student to achieve the following results:

- The appreciation of the influence of social, political and cultural factors in relation to health care and advising on the promotion of health
- The recognition of common factors which contribute to, and those which adversely affect, the physical, emotional and social well-being of the mother and baby, and the taking of appropriate action
- The ability to take action under her independently, including the initiation of the action of other disciplines, and to seek assistance when required
- The ability to interpret and undertake care prescribed by a registered medical practitioner
- The use of relevant literature and research to get informed about the practice of midwifery
- An understanding of the requirements of legislation and ethical issues (ibid.)

The government funds the universities via regional health education boards, which make an agreement with local universities for professional health education according to predicted staffing needs.



19.6 Developments

There have been a lot of developments. The 'Association of Radical Midwives' tries to resist the threats and to look for changes to strengthen the position of midwives.

19.6.1 Threats

Almost all births take place in hospital, resulting in an over-reliance on technology. According to the Association of Radical Midwives, this is a threat to physiological births and it is in conflict with the dominant midwifery view of pregnancy and birth as natural events. Most midwives work in hospitals (more than 60%), and this can again make it difficult to realise the midwifery view of pregnancy and birth. The remaining community-based midwives (c. 37%) are often governed by hospital-based protocols.

There is a shortage of midwives and the fact that too much midwifery time is being taken up with other activities compounds this problem.

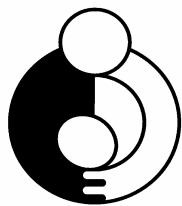
There is no professional indemnity insurance for independent midwifery practice. This discourages midwives from starting their own practices and is therefore bad for the independence of midwives.

19.6.2 Opportunities

In the United Kingdom the midwifery profession is vocal and well organised. There is a well-organised and powerful lay childbirth lobby that supports midwifery-led care.

There is a commitment to evidence-based practice and the further development of knowledge through research.

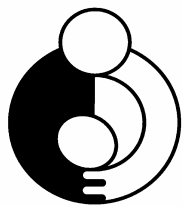
There is some degree of understanding that women should have information and a free choice at all levels and there are many attempts to turn this into reality.



19.7 Statistics

Year	1999	2000
Inhabitants		59,500,000
Birth-rate	635,901	
Born alive	632,531 (99.47%)	
Stillborn	3,370 (0.53%)	
Perinatal mortality rate	0.82%	
Midwives		33,291 (90,378 registered)
Births per midwife		30
Gynaecologists	1,153	
General practitioners active in midwifery care		

The definition of perinatal mortality is the number of stillborn and deaths after 24 completed weeks gestation and before 6 completed days per 1000 births (Royal College of Obstetricians and Gynaecologists 2001).



20. Summary and conclusions

The research shows that over the last decades many changes have taken place with regard to midwifery in Europe. Some of these changes have had a positive effect on the position of midwives, for example, the protection of professional groups by law. From the 20th century onwards, the tasks and responsibilities have been protected in almost all European countries. Future changes regarding the level of education and initiatives for more independent pursuance of the profession (e.g. midwife-led units) will contribute to a better position for midwives in some countries.

But other changes are putting pressure on the position of midwives. The most important threats will be discussed in paragraph 20.1.

20.1 Threats

20.1.1 Trend towards 'medicalisation'

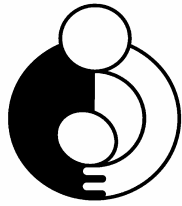
Since the 1960s, the general trend with respect to health care in Europe has been 'medicalisation'. For midwifery care this means that there is a movement from primary to secondary care. The delivery does not take place at home anymore, but it takes place in hospital. Interest in medical technology is also increasing. As a consequence the physiological view on pregnancy and birth in some countries is being repressed or dominated by a pathological view. In many European countries, pregnancy and birth are no longer considered as natural processes, but as potential risks for both the mother and child. In countries with this pathological view, the midwife has a limited role and she is less independent.

20.1.2 Strong influence of gynaecologists

Gynaecologists are very important in midwifery care. In some countries they are the obvious persons (primary care provider) for the women to turn to, also during her normal pregnancy and birth. In these countries women do not usually have the choice of a different provider. This is contrary to the midwives' pursuit for independence.

20.1.3 Midwife is not ultimately responsible

In some European countries, the midwife (almost) always works under the responsibility and/or direct supervision of the gynaecologist. This situation can be threatening for the independence of midwives.



20.1.4 Lack of influence

Up until now, midwives could not influence and convince politicians, gynaecologists and society of the advantages of a physiological approach of pregnancy and birth. This is partly due to the absence of evidence based research.

20.1.5 No identity of their own

In a number of countries, the profession of midwives is strongly connected with the profession of nurses. As a consequence, midwives perform tasks of nurses and vice versa. The fact that midwives do not have an identity of their own, limits the possibilities of strengthening their position.

20.1.6 Only hospital birth covered

In some countries the health insurer or government only reimburses hospital births. This is a strong financial incentive for parents to deliver in hospital.

20.1.7 Limited freedom of choice

In practice, parents often have no, or a limited freedom of choice with regard to both their primary care provider and the place of birth. The position of midwives is threatened when parents are legally obliged to seek help from gynaecologists and/or to visit hospitals to give birth.

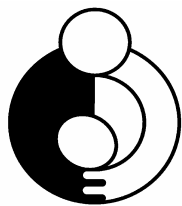
Most of the above threats are connected. They maintain and enhance each other. Because of these developments, the position of midwives as described in the EU-directives, is being threatened.

20.2 Conditions

To maintain and strengthen the position of midwives, it is necessary that the health care system fulfils some conditions.

I. Strong professional body

In all European countries there should be a strong professional body, which can propagate the physiological view and stimulate the professional group of midwives to obtain a better position. The EMLC should attract the professional bodies that represent the majority of midwives in their countries, in order to represent all midwives in Europe.



II. Agreement about the physiological view

Gynaecologists, midwives and society should support the view that pregnancy and birth are natural processes in principle.

III. Freedom of choice

Parents should be able to choose their primary care provider and the place of birth, provided that parents have enough information with which to make a legitimate choice.

IV. Finance system linked to the physiological view

The finance system should be organised in such a way that it does not influence the choices of parents and procedures of professionals through rules and regulations, unless the system is in compliance with the physiological view.

V. To promote evidence based research

Evidence based research is a method to persuade others (e.g. gynaecologists and society) of the additional value of midwifery care. Furthermore, it can support the upgrading of quality in the midwifery profession. It is advisable to introduce scientific research as a fixed subject in the course. And it could be stimulated after the course, by subsidising those who perform evidence based research in practice.

VI. To improve the quality of care

To guarantee the quality of care, the midwife's course should be of a high level (e.g. bachelor). To improve the quality of care, various methods should be used, such as evaluation and post-graduate courses.

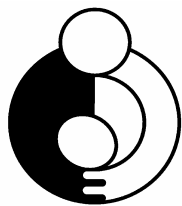
VII. To improve the status of the profession

To supply enough midwives, it is important to make the profession attractive. This can be realised through good salaries, favourable terms of employment and social appreciation.

20.3 To continue

The purpose of this study is to make an inventory of the midwifery systems in all fifteen countries of the European Union. Some recommendations for future research and policies of the EMLC are presented here.

In the directives of the European Union, the definition and job description of the WHO/FIGO are used. Officially, those apply to all midwives in Europe. In practice



however, the tasks of midwives often do not comply with these descriptions. As can be seen, the EMLC has two options of views to represent; either all midwives should be working according to these descriptions, or in every country all midwives should be working in a way that fits the system.

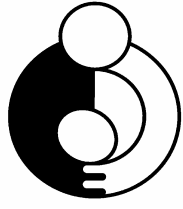
The EMLC should make a choice between these two possibilities. She should first take a stand on the content of the midwifery profession, before she can represent it at a European level. The researchers recommend the EMLC to choose and actively support the midwives with working according to the EU-directives. Because most of the representatives of the umbrella organisations have expressed their wishes to do so, it would also simplify comparisons between countries and it could strengthen the position of midwives.

The study shows that the midwifery systems are difficult to compare, because of the differences in history and culture. During the research it was also apparent that linguistic problems and different interpretations of apparently simple definitions hindered a comparison in horizontal terms. Still, the EMLC wishes to represent all these different systems in the European Union. Therefore, it is necessary that the EMLC has a certain amount of basic data.

In spite of all the efforts (desk research, interviews etc.) the basic data, like the number of midwives per country and the total costs for midwifery care did not come up. The researchers argue that the EMLC should encourage and support countries in setting up registrations for this data. Before this is possible, the EMLC should develop a view about which basic data it wishes to have. This also depends on the goals the EMLC wishes to attain. After that, the EMLC should see to it that the data is representative and up-to-date.

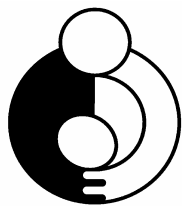
The researchers would like to emphasise research is a necessity in supporting the midwives to develop their position within the health care systems. Together with the establishment of strong national professional organisations for midwives, research will help to convince and influence politicians, gynaecologists and society of the advantages of a more physiological approach of pregnancy and birth. The results will also help to convince midwives themselves at first.

In conclusion, the researchers believe that the goal of making an inventory in all EU-member states about their midwifery systems has been reached; a 'photo' has been taken of every midwifery system. While some systems are brought into focus quite well, other photos may appear to be somewhat vague. Still, thanks to all the efforts put in by all participants, the EMLC will now be able to develop future policy in order to strengthen midwives' position on the basis of the descriptions and recommendations given in this report.



**Deloitte
& Touche**

Supplements



Supplement 1: Names of all participants

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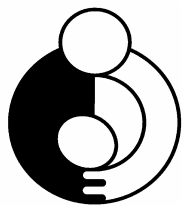
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Mrs. Maria Alexandra Amaral (Portugal)

Mr. Vitor Varela (Portugal)

Mrs. Gloria Seguranyes (Spain)



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Remaining

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Mr. John Menaa (Denmark)

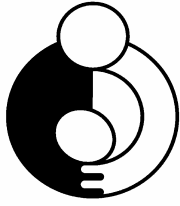
Dr. Roland Rausch (Germany)

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Mr. Marcello Romano (Italy)

Mr. Gary Baker (Sweden)

Mr. Frank Wilson (United Kingdom)



Supplement 2: Questionnaire

This research has been done by the EMLC and Deloitte & Touche to gain insight into the midwifery systems in all European Union member states.

We kindly request you to fill in this questionnaire completely.
The questions refer to the situation in your own country.
Please specify your sources of information.

The information will only be used for this study. The information will be used in preparation for the group meeting in The Netherlands on the 21st and 22nd of June and all results will be presented in Barcelona on the 21st and 22nd of September.

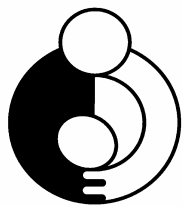
Please return the questionnaire no later than the 11th of May.

Instructions for filling in this questionnaire

Please fill in the facts from the year 2000, and if not available the most recent numbers and information. Please specify the year.

Ring or tick the answers where appropriate.

Please do not use abbreviations.



The subjects that are discussed in this questionnaire are:

- I. Birth and death rates
- II. Midwifery
- III. Supply
- IV. Obstetric system
- V. Finance structure
- VI. Education
- VII. Historical developments
- VIII. Opportunities and threats
- IX. In conclusion

Personal data

Name umbrella organisation _____

Name contact _____ m/f

Profession _____

Organisation _____

Country _____

Email _____

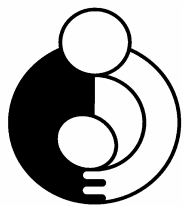
Telephone _____

I. Birth and death rates

In this paragraph we are asking some general statistics about birth and death rates. Please, fill in the numbers of the year 2000 (if not available please fill in the most recent numbers and specify the year).

1. What is the total number of births?

.....

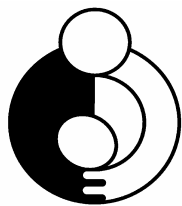


2. What percentage is born alive?
3. What is the definition of perinatal mortality?
-
-
-
4. What is the perinatal mortality rate?

II. Midwifery

In this paragraph we would like to know more about the functions of a midwife and midwifery care.

5. Give the common definition of a midwife.
-
-
6. Give a brief description of the activities that a midwife practices in the following phases, if applicable.
- (a) Antenatal care.....
-
-
-
-
-
- (b) Natal care.....
-
-
-
-



(c) Postnatal care.....

.....

.....

.....

(d) Other.....

.....

.....

7. Is a midwife able to care for a normal pregnancy or birth on her own responsibility? Please ring the answer.

	Yes totally	Yes partially	No	Not applicable
(a) Antenatal care	1	2	3	4
(b) Natal care	1	2	3	4
(c) Postnatal care	1	2	3	4

8. Is a midwife able to care for an abnormal (medium risk/high risk) pregnancy or birth on her own responsibility? Ring the answer.

	Yes totally	Yes partially	No	Not applicable
(a) Antenatal care	1	2	3	4
(b) Natal care	1	2	3	4
(c) Postnatal care	1	2	3	4

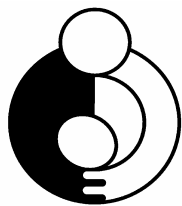
9. What is the prevailing view on pregnancy and birth in general?

(a) Natural process yes/no

(b) Pathological process yes/no

(c) Other,.....

.....



10. What is the prevailing view among midwives on pregnancy and birth?

(a) Natural process yes/no

(b) Pathological process yes/no

(c) Other,.....

.....

11. Is the profession of midwives protected by law? yes/no

If yes, which law(s) and since when?.....

.....

12. Are the functions and activities of midwives protected by law? yes/no

If yes, which law(s) and since when?.....

.....

III. Supply

In this paragraph we want to make an inventory about the number of people that are working in midwifery care.

13. How many midwives are available per 1000 fertile women?.....

14. How many midwives practice midwifery in your country?.....

15. How many midwives are registered in your country?.....

16. How many of them are female?.....

17. Describe the age structure of the midwives.....

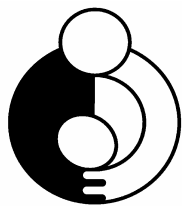
.....

.....

18. How are midwives employed?

(a) In independent free practice yes/no

If yes, what percentage?.....



(b) In the public sector yes/no

If yes, what percentage?.....

(c) In the private sector yes/no

If yes, what percentage?.....

19. How many gynaecologists are there?.....

20. How many general practitioners or family doctors are active in midwifery care?

.....

IV. Obstetric system

In this paragraph we are going to ask you some questions about all professional groups that are active in midwifery care.

21. Which professional groups are active in midwifery care, in the different phases?
Ring all that apply.

(a) Antenatal care

1. Midwife

2. Gynaecologist

3. Paediatrician

4. General practitioner/ Family doctor

5. Organised maternity care

6. Others,.....

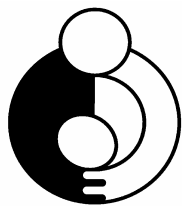
(b) Natal care

1. Midwife

2. Gynaecologist

3. Paediatrician

4. General practitioner/ Family doctor



5. Organised maternity care

6. Others,.....

(c) Postnatal care

1. Midwife

2. Gynaecologist

3. Paediatrician

4. General practitioner/ Family doctor

5. Organised maternity care

6. Others,.....

22. Who has the final responsibility in the different phases, in case of a normal pregnancy and birth?

(a) Antenatal care

1. Midwife

2. Nurse

3. Nurse-midwife

4. Gynaecologist

5. Paediatrician

6. General practitioner/ Family doctor

7. Others,.....

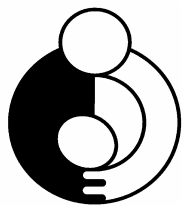
(b) Natal care

1. Midwife

2. Nurse

3. Nurse-midwife

4. Gynaecologist



5. Paediatrician
6. General practitioner/ Family doctor
7. Organised maternity care
8. Others,.....

(c) Postnatal care

1. Midwife
2. Nurse
3. Nurse-midwife
4. Gynaecologist
5. Paediatrician
6. General practitioner/ Family doctor
7. Organised maternity care
8. Others,.....

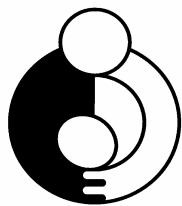
23. Who has the final responsibility in the different phases, in case of an abnormal pregnancy and birth?

(a) Antenatal care

1. Midwife
2. Gynaecologist
3. Paediatrician
4. General practitioner/ Family doctor
5. Others,.....

(b) Natal care

1. Midwife
2. Gynaecologist



3. Paediatrician
4. General practitioner/ Family doctor
5. Organised maternity care
6. Others,.....

(c) Postnatal care

1. Midwife
2. Gynaecologist
3. Paediatrician
4. General practitioner/ Family doctor
5. Organised maternity care
6. Others,.....

24. What percentage of deliveries took place under responsibility of a midwife in the year 2000?

.....

25. What percentage of deliveries took place under responsibility of a gynaecologist in the year 2000?

.....

26. What percentage of deliveries do midwives conduct?

.....

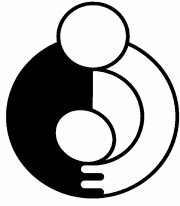
27. What percentage of deliveries do gynaecologists conduct?

.....

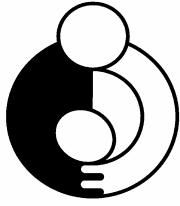
28. Do rules and legislation regulate the responsibilities? yes/no

If yes, which law(s) and since when?.....

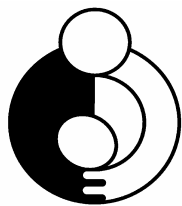
.....



29. Where do the deliveries take place? Ring all that apply.
- (a) At home
 - (b) In the hospital
 - (c) In a maternity clinic
 - (d) Else,.....
30. Who decides where the delivery takes place?
- (a) Midwife
 - (b) Gynaecologists
 - (c) General practitioner/ Family doctor
 - (d) Parents
 - (e) Others,.....
31. In which cases does the delivery take place at home? Ring all that apply.
- (a) At the parents' request
 - (b) In case of a normal pregnancy
 - (c) By accident
 - (d) Never
 - (e) Otherwise,.....
32. In which cases does the delivery take place at the hospital? Ring all that apply.
- (a) Always
 - (b) At the parents' request
 - (c) In case of an abnormal pregnancy
 - (d) Never
 - (e) Otherwise,.....



33. In which cases does the delivery take place at a maternity clinic? Ring all that apply.
- (a) Always
 - (b) At the parents' request
 - (c) In case of a normal pregnancy
 - (d) Never
 - (e) Otherwise,.....
34. Where is the maternity care provided? More answers possible.
- (a) Home yes/no
 - (b) Hospital yes/no
 - (c) Maternity clinic yes/no
35. Who delivers this maternity care? More answers possible.
- (a) Midwife
 - (b) Maternity nurse
 - (c) Community nurse
 - (d) Family
 - (e) Others,.....
36. How does one come under care of a midwife? (Describe the procedure of reference)
-
-
37. How does one come under care of a gynaecologist? (Describe the procedure of reference)
-
-



V. Finance structure and income

In this paragraph we want you to describe your insurance system in general. But first we will explain what we mean by finance structure.

Compulsory systems of finance are those under an obligatory public scheme. They may be based on tax sources of various kinds or on statutory health insurance. Statutory health insurance (also termed 'social' or 'public' health insurance) refers to health insurance funded by compulsory payment of (usually) income-related contributions by employers and employees. Public bodies or quasi-public bodies usually administer compulsory systems, although there are some cases in which private insurers may administer statutory insurance.

Voluntary systems are those in which finance is left to the discretion of the individuals, either through direct, out-of-pocket payments or through voluntary purchase of insurance, sometimes by employers on behalf of the individual. Voluntary insurance is usually purchased from private insurance organisations, although in some cases it may also be purchased from public or quasi-public bodies.

For most countries in the European Region, taxation, statutory health insurance or a combination of the two, form the main sources of finance.

Please give a short explanation of your answers.

38. What were the total costs for midwifery care in the year 2000?.....

Euro.....

Local monetary unit.....

39. What percentage of health care is funded by the compulsory system?.....

40. How does the compulsory system finance health care?

(a) By taxation

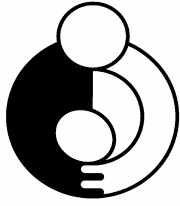
(b) By social insurance premiums

(c) Both

If both, what percentage is financed by taxation?.....

And what percentage is financed by social insurance premiums?.....

Please explain your answer.....



41. What percentage of health care is financed by the voluntary system?.....
.....

42. How does the voluntary system finance health care?

(a) Through direct, out-of-pocket payments

(b) Through voluntary insurance

(c) Both

If both, what percentage is funded by direct payments?.....

And what percentage is funded by voluntary insurance?.....

Please explain your answer.....
.....

43. What are the most important legislations that are applicable on the health insurance system and what are the purposes of these laws?
.....
.....

44. Do midwives enter into contracts? yes/no

If yes, with whom, about what and how?.....
.....

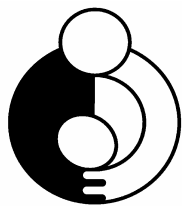
45. Do women need insurance for midwifery care? yes/no

If yes, go to question 46

If no, go to question 48

46. What kind of midwifery care does the social insurer reimburse in the following phases, if applicable?

(a) Antenatal care.....
.....



(b) Natal care.....

.....

.....

(c) Postnatal care.....

.....

.....

47. What kind of midwifery care does the private insurer reimburse in the following phases, if applicable?

(a) Antenatal care.....

.....

.....

(b) Natal care.....

.....

.....

(c) Postnatal care.....

.....

In case women can choose to which professional they go, without any restraints, then there will be competition between professionals.

48. Is there competition between midwives themselves? yes/no

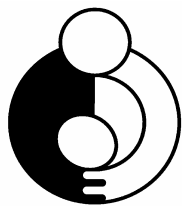
Explain your answer

.....

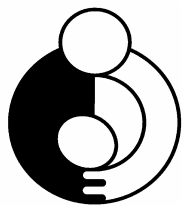
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49. Is there competition between midwives and gynaecologists? yes/no

Explain your answer.....



50. Is there competition between midwives and general practitioners? yes/no
Explain your answer.....
.....
.....
51. What legislation is applicable on competition in midwifery care and what are the purposes of these laws?
.....
.....
.....
52. Is there co-operation between midwives? yes/no
If yes, describe this co-operation.....
.....
.....
.....
53. Is there co-operation between midwives and gynaecologists? yes/no
If yes, describe this co-operation.....
.....
.....
54. Is there co-operation between midwives and general practitioners? yes/no
If yes, describe this co-operation.....
.....
.....
55. How are midwives paid? Ring all that apply.
(a) Salaried employment

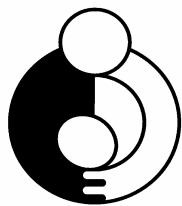


- (b) Per client
- (c) Fee for service
- (d) Otherwise,.....
56. How is the income of midwives being set?.....
.....
.....
57. What legislation is applicable on midwives income and what is the purpose of these laws?
.....
.....
58. What is the average income of midwives annually?
- Euro.....
- Local monetary unit.....

VI. Education

In this section we would like to know something about the education to become a midwife.

59. What preliminary training is necessary?.....
.....
60. What are the (remaining) admission requirements?.....
.....
61. How long is the training period to become a midwife?
.....
62. Give a short description of the contents of the education. Describe for instance the subjects that are dealt with.



.....
.....
63. Which practicals does a student have to do during the education, concerning the following phases? And describe how many weeks and activities it takes to do these practicals.

(a) Antenatal care.....

.....

(b) Natal care.....

.....

(c) Postnatal care.....

.....

64. What is the total capacity of the education annually?.....

65. Who is responsible for the education?

(a) Hospital

(b) Institute

(c) Private

(d) Government

(e) Other,.....

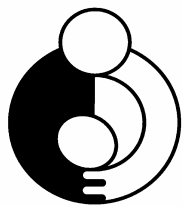
66. What legislation is applicable on midwife's education and what are the purposes of these laws?

.....

.....

VII. Historical developments

Give a brief account of the key factors influencing the midwifery system in your country in the twentieth century.



67. Please consider transformations regarding:

- Function/competencies
- Job responsibilities
- Technological possibilities
- Place of birth
- Supply
- Finance structure and reimbursement
- Income
- Education

If there is another subject that you think is relevant, please inform us about it.

.....

.....

.....

.....

.....

.....

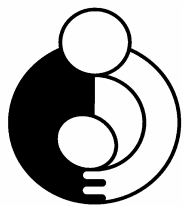
.....

.....

.....

VIII. Opportunities and threats

In the current situation there can be many developments. As a result, new opportunities and threats arise. To determine these opportunities and threats, it is important to know the view and purposes of midwifery.



68. What view does the umbrella organisation have on midwifery?

.....

.....

.....

.....

69. What purposes does the umbrella organisation have?

.....

.....

.....

.....

70. Describe three positive items of your obstetric system.

.....

.....

.....

.....

71. Describe three negative points of your obstetric system.

.....

.....

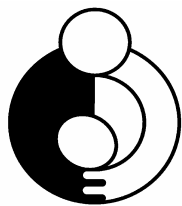
.....

.....

72. Describe three items which, according to your umbrella organisation, should be changed.

.....

.....



73. If any changes will be taking place in the near future in the general health care system in your country, what is the influence of these changes on the function and position of midwives?

.....

74. If any changes will be taking place in the near future in the midwifery system in your country, what is the influence of these changes on the function and position of midwives?

.....

.....

.....

.....

IX. In conclusion

If you have missed any important subjects in this questionnaire, or you would like to explain your answers further. Please write down your comments and any additional information that you think is relevant.

.....

.....

.....

Thank you very much for your co-operation and the efforts you made to fill out this questionnaire.

Please return the questionnaire not later than May 11th 2001 to:

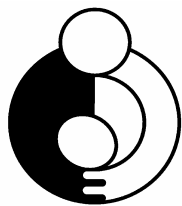
Deloitte & Touche Bakkenist

Mandy Luiten and Josine Emons

P.O. Box 336

3830 AJ Leusden

The Netherlands



Supplement 3: Ideal midwifery

During the group meeting in Amsterdam on the 21st and 22nd of June, there was a discussion about what would be the ideal midwifery system according to the midwives. What characteristics should an ideal midwifery system contain?

In chapter 20 it has been said that to maintain and strengthen the position of midwives, it is necessary that the health care system fulfils some conditions. The umbrella organisations agreed on those conditions.

Besides the conditions mentioned in chapter 20, the umbrella organisations also named a number of other requirements that should be present in an ideal midwifery system. Those will be described below.

❖ EU-directives

According to the umbrella organisations, all midwives in Europe should practice according to the EU-directives 80/154/EEC and 80/155/EEC. They should do the tasks and have responsibilities as laid down in the directives. The process of pregnancy (and birth) has to be started by the midwife. Midwives have to take the lead.

❖ Place of birth

The place of birth should meet the women's demand. They should not only be able to give birth at home and in hospital, but also in midwife-managed maternity units.

❖ Self-employment and salary

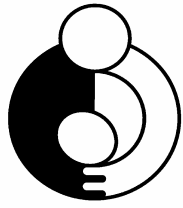
Midwives should have the choice of being employed or independent.

❖ Number of midwives

On the basis of the amount of tasks and the time available, the number of midwives needed has to be calculated and consequently be increased, to reduce the pressure of work.

❖ Finance

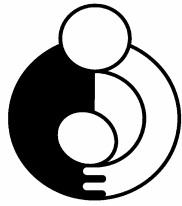
Midwifery care should be publicly financed and it should be equally accessible to everyone.



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❖ Education

The education should at least be at bachelor-level and should contain subjects such as evidence based research.



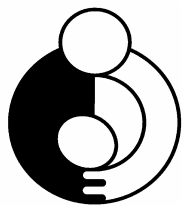
Supplement 4: Tables

Even though it is hard to compare the different midwifery systems in general and some subjects specifically, because of the differences in historical developments and cultures, it is nice to have an overall view. The tables present the results not per country, but per subject.

While every midwifery system has its own characteristics and does not seem to match the others, the countries seem to agree on the professional who is responsible for midwifery care when the pregnancy and/ or birth shows signs of complications (table 2.2). In these cases the gynaecologist is always mentioned as the primary care provider.

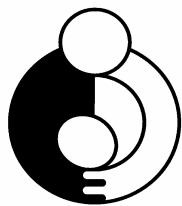
In all EU-member states the hospital is the main place of birth. And all umbrella organisations support the view that pregnancy and birth are natural processes to begin with, as is shown in table 3.

Looking at the tables, one should remember that not all concepts presented here are defined in the same way in every country. For example, there are many different definitions of the perinatal mortality rate.



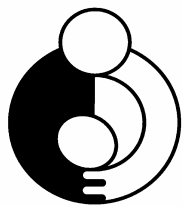
	Inhabitants	Births	Born alive	Stillborn
Austria	7,900,000	77,887	99.59%	0.41%
Belgium	10,100,000	114,276	99.30%	0.70%
Denmark	5,200,000	64,792 (1998)		
Finland	5,100,000	57,345 (1998)	99.60% (1998)	0.4% (1998)
France	57,700,000	736,487 (1995)	99.30%	0.70%
Germany	82,000,000	770,744	99.60%	0.40%
Greece	10,400,000	101,491		
Ireland	3,500,000	54,239	99.50% (1997)	
Italy	57,200,000	525,428	99.60%	0.37%
Luxembourg	400,000	5,596	99.70%	0.30%
The Netherlands	16,000,000	200,445		
Portugal	9,800,000	116,691	99.40%	0.60%
Spain	39,600,000	377,809		
Sweden	8,882,792	88,512	99.60%	0.40%
The United Kingdom	59,500,000	635,901	99.47%	0.53%

Table 1: Statistics 1999/2000 (part 1)



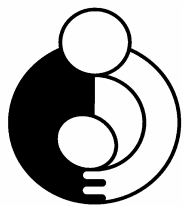
	Midwives	Births per midwife	Gynaecologists	GP's active in midwifery
Austria	1,550	50	590	5.0%
Belgium	4,351		450	
Denmark	3,500		880	3,500
Finland	1,770	24.6	584	1,950
France	15,027		4,674	
Germany	15,000		15,000	
Greece	2,300	3	2,176	0
Ireland	39,000 (incl nurses)		81	
Italy	14,500		12,000	
Luxembourg	60-70		70-80	0
The Netherlands	1,578	120-130	>613	1,120
Portugal	1,100	53	ca 700	
Spain	5,000		5,000	
Sweden	8,504		1,803	
The United Kingdom	33,291	30	1,153	

Table 1: Statistics 1999/ 2000 (part 2)



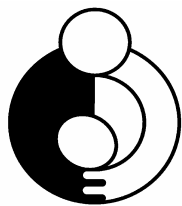
	Normal antenatal	Normal natal	Normal postnatal
Austria	midwife/ gynaecologist	midwife/ gynaecologist	midwife/ gynaecologist
Belgium	midwife	midwife	midwife
Denmark	midwife	midwife	midwife
Finland	general practitioner/ gynaecologist	gynaecologist	general practitioner/ gynaecologist
France	midwife	midwife	midwife
Germany	midwife/ gynaecologist	midwife/ gynaecologist	midwife/ gynaecologist
Greece	gynaecologist	gynaecologist	gynaecologist
Ireland	midwife	midwife	midwife
Italy	midwife/ gynaecologist	midwife/ gynaecologist	midwife/ gynaecologist/ paediatrician
Luxembourg	gynaecologist/ paediatrician	gynaecologist/ paediatrician	gynaecologist/ paediatrician
The Netherlands	midwife	midwife	midwife
Portugal	midwife/ gynaecologist	midwife/ gynaecologist	midwife/ gynaecologist
Spain	midwife	midwife	midwife
Sweden	midwife	midwife	midwife
The United Kingdom	midwife	midwife	midwife

Table 2.1: The professional final responsible in normal case



	Abnormal antenatal	Abnormal natal	Abnormal postnatal
Austria	midwife/ gynaecologist	midwife/ gynaecologist	midwife/ gynaecologist
Belgium	gynaecologist	gynaecologist	gynaecologist
Denmark	gynaecologist	gynaecologist	gynaecologist
Finland	gynaecologist	gynaecologist	gynaecologist
France	gynaecologist	gynaecologist	gynaecologist
Germany	gynaecologist	gynaecologist	gynaecologist
Greece	gynaecologist	gynaecologist	gynaecologist
Ireland	midwife/ gynaecologist	midwife/ gynaecologist	midwife/ gynaecologist
Italy	gynaecologist	gynaecologist	gynaecologist/ paediatrician
Luxembourg	gynaecologist/ paediatrician	gynaecologist/ paediatrician	gynaecologist/ paediatrician
The Netherlands	gynaecologist	gynaecologist	gynaecologist
Portugal	gynaecologist	gynaecologist	gynaecologist
Spain	gynaecologist	gynaecologist	gynaecologist
Sweden	gynaecologist	gynaecologist	gynaecologist
The United Kingdom	gynaecologist	gynaecologist	gynaecologist

Table 2.2: The professional final responsible in abnormal case

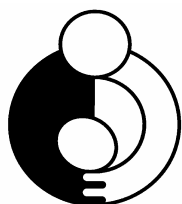


	View society	View midwives	Main place of birth
Austria	N	N	Hospital/ Maternity clinic
Belgium	N	N	Hospital
Denmark	N	N	Hospital/ Maternity clinic
Finland	N	N	Hospital
France	N and P	N and P	Hospital
Germany	N	N	Hospital
Greece	P	N	Hospital
Ireland	N and P	N and P	Maternity clinic
Italy	N	N	Hospital
Luxembourg	P	N and P	Hospital
The Netherlands	N	N	Home/ Hospital
Portugal	N and P	N	Hospital
Spain	N	N	Hospital
Sweden	N	N	Hospital
The United Kingdom	N and P	N	Hospital

N = Natural view

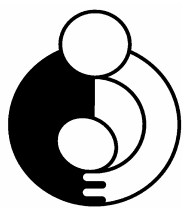
P = Potential pathological view

Table 3: View on pregnancy and birth and main place of birth



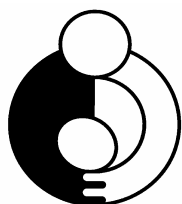
	Main organisation of employment	Average income annually
Austria	Hospital (60%) Hospital + self-employed (30%)	
Belgium	Public hospital	€17,000
Denmark	Public hospital Public maternity clinic	€33,500
Finland	Public hospital Maternity clinic	€26,910
France	Public hospital (60%) Private hospital (25%) Independent (15%)	€23,739
Germany	Public hospital	€26,610
Greece	Public hospital Public maternity clinic	€11,739
Ireland	Public hospital	
Italy	Public hospital (80%) Private sector (10%) Independent (10%)	€15,500
Luxembourg	Public hospital	€30,000
The Netherlands	Independent (69%) Public hospital (16%)	€30,151
Portugal	Public hospital (100%) Private maternity clinic	€24,500
Spain	Public hospital (90%)	€21,868
Sweden	Public hospital Antenatal health care centres	€26,000
The United Kingdom	Public hospital Birth centres	€29,700

Table 4: Main organisations of employment and annual income of midwives in Europe.



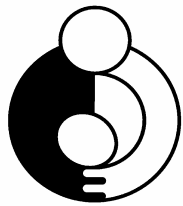
	Level	Duration	Admission requirements
Austria	University	3 years	University entrance qualification
Belgium	University	3 or 4 years	Secondary school diploma
Denmark	Higher	3.5 years	Student's degree + 9 months working experience
Finland	Higher	1.5 years	Nurse diploma + good state of health + aptitude test
France	University	4 years	Baccalaureate
Germany	Higher	3 years	Diploma Realshule + good state of health
Greece		112 weeks	National exams
Ireland	University	2 years	General nurse diploma + working experience
Italy	University	3 years	High school diploma
Luxembourg	Higher	2 years	General nurse diploma
The Netherlands	Higher	4 years	High school diploma with biology and chemistry
Portugal	University	88 weeks	Nurse diploma + 2 years working experience
Spain	University	2 years	Nurse diploma + National exam
Sweden	Higher	1.5 years	Nurse diploma + 6 months working experience
The United Kingdom	University	3 years	Higher educational level incl. A science and English + age of 17

Table 5: Midwifery education in Europe (part 1).

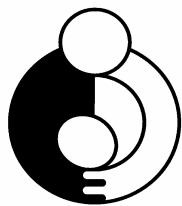


	Hours of practical classes	Hours of theoretical classes	Students (total)
Austria	1.530	3.250	
Belgium	1.025	1.575	750
Denmark			ca. 300
Finland			200
France	4.370	1.820	ca. 2.900
Germany	3.000	1.600	1.800
Greece	(70 weeks)	1.470	300
Ireland	2.574	1.014	280
Italy	3.800	1.600	700
Luxembourg	2.300	700	10
The Netherlands	3.560	3.160	700
Portugal	1.350	1.050	100
Spain	2.500	1.100	150
Sweden			200-250
The United Kingdom	2.500	2.500	12.000

Table 5: Midwifery education in Europe (part 2).



**Deloitte
& Touche**



Supplement 5: Literature

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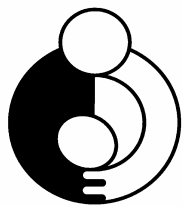
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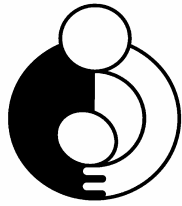
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Wetenschappelijke Vereniging