Choice in maternity care and childcare policies in the Netherlands and Germany

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Introduction

Welfare states in Europe have undergone significant changes since the late 1980s, which have included shifts away from previously assigned regime-specific characteristics in state-market-family relationships. The organization of care has been a key point of contention, and countries have found different strategies to address the issue in the context of new economic and social challenges.

First, economic changes such as the restructuring of labour markets and growing female labour market participation, made conflicts of family-employment reconciliation particularly visible. Second, changes in family dynamics including postponements in first births, marriage decline, increases in divorce and separation as well as population ageing, together diversified the landscapes of family arrangements and care relationships across Europe. New social risk structures emerged in the post-industrial social order, posing new demands on and challenges to welfare states (Bonoli 2005). Common responses to such changes have included increased emphasis on labour market activation and social investment policies as well as introducing a new narrative of self-responsibility for economic security.

The narrative of self-responsibility has entered the sphere of care as well, although it is less clear what shape it takes here. While care is often regarded as a matter for private responsibility and decision-making (Lewis 2008), the impetus to increasing state involvement in care has arguably also grown in the post-industrial setting. Bismarckian welfare states, too, have paid more attention to work-family reconciliation despite their traditionally familialist approach of relying on unpaid care work in families. But as we will show in this paper, narratives and organization of care show diverging trends even within particular types of welfare regimes.

In this paper, we investigate to what extent choice as a narrative and factual choice have entered care policies in the Dutch and German welfare states over the past decades. We ask: Is the choice narrative and factual choice in care-related policies increasing, and if yes in which direction? What were the drivers of choice, if any? The countries studied share the characteristics of a familialist Bismarckian welfare state model, but their approaches to care policy vary and have diverged over time.

By analysing developments in two types of care-related policies, childcare and maternity care policy, our study contributes to previous research in three ways: First, we extend accounts of change in care-related policies by investigating the often-neglected field of maternity care policy. Second, analys-

ing two types of care-related policies allows to assess whether welfare states take a coherent approach across policy domains. Third, we contribute to understand variation in Bismarckian responses to post-industrial social challenges, i.e. what have changes in the focus on choice meant in the respective welfare states?

The paper is structured as follows. In Section 2, we describe the key characteristics of childcare policy and maternity care policy in the Netherlands and Germany as they evolved over time. In Section 3, we map the development in the role of choice in the two systems. In Section 4, we comparatively analyse choice narratives and factual choice in the two policy domains. We conclude with a discussion of the main findings and an outlook on the next steps of our research.

Care policies

Netherlands: childcare policy

In the Netherlands, family policy has traditionally supported a strong male breadwinner–female housewife model. This arrangement has shifted to an institutionalized one-and-a-half earner model through incentivizing part-time work and providing schemes for families to do both – work and care. Like in the German case, family care was viewed as superior to formal childcare arrangements, but the Dutch model focused on the home rather than the mother as the ideal locus of child development. While the Social Democratic and Christian Democratic coalition in the 1990s recognized the need for public childcare, the following governments of right-wing liberals, Christian Democrats and small parties reduced the role of the state and placed care responsibility back in the hands of the family (Knijn 2008). Childcare provision today is privatized and expensive; parental leave is not paid, which means that families with higher incomes overall have more flexibility over work and care arrangements than those with lower incomes. Childcare use is thus relatively segmented due to high costs, and furthered by employer-based funding schemes (Morel 2007). Private childminders are a widespread form of childcare for those able to afford it. Since the 1980s, there is a trend towards decentralization of public services including childcare characterized by shared responsibility (between the state, employers and parents) and self-regulation. Childcare is commonly provided for half days, and accordingly part-time is the dominant form of employment for women in the Netherlands. There are schemes that allow employees to save up salary for temporary breaks, which shifts responsibility (and costs) from the state to the employee and the market.

Germany: childcare policy

Family policy in West Germany has traditionally been oriented towards preserving the family as an institution characterized by a male breadwinner and a maternal caretaker. The family policy system was characterized by a cash bias, featuring care allowances to complement the earner's income as well as tax regulations supporting the male breadwinner–female housewife model (Gerlach 2009). Childcare was considered mothers' responsibility, and non-maternal care was viewed as inferior and unnecessary. With economic and social conditions stabilizing in the 1960s, formal childcare arrangements became more widespread. Formal childcare was provided through a subsidized third-sector system, but mainly on a part-time basis and with limited coverage. Although childcare was widely used, it was mainly targeted at older children (age 4 and above) (Oliver, Mätzke 2014). A shift to what was called 'sustainable family policy' was visible from 2005 (Rürup, Gruescu 2006; BMFSFJ 2006). Mätz-

ke and Ostner (2010) have usefully described this shift as a turn away from supporting the family as an institution to treating it more as a group of individuals with different needs. The new approach was motivated by economic and demographic arguments, and included a commitment by the government to provide stronger support for reconciling family life and employment, especially allowing mothers to participate in the labour market, to incentivize fertility, and to improve child wellbeing (BMFSFJ 2006). Parental rights to time, infrastructure and money were to be extended in order to reach these goals. Childcare was a key component in this arrangement, as it was seen to serve both, the goals of supporting female employment and that of child wellbeing. Between 2007–2014, the federal government directed large funds towards the expansion of childcare facilities, and in 2013 installed a legal right to a place in a childcare centre for all children aged 1 year and above. The Länder governments have since worked on implementing the new directives, but large regional differences in provision remain (Oliver, Mätzke 2014).

Netherlands: maternity care policy

The Dutch Maternity Care System is considered unique within the group of advanced, industrialized countries with its strong support for the midwifery model and non-interventionist births (De Vries 2001). The model is based on an established division of labor between low-risk pregnancies, which receive care within the primary care system from midwives (and rarely general practitioners), and high-risk pregnancies, which are cared for in secondary care by obstetricians in hospitals (Amelink-Verburg, Buitendijk 2010). Whether women receive primary or secondary care is thus determined by an assessment of the pregnancy risk. The risk assessment and decision are in the hands of the midwife who has the role of the gatekeeper to specialist care. The risk assessment is based on an official List of Obstetric Indications (LOI) developed by midwives and obstetricians (Amelink-Verburg, Buitendijk 2010). Women with a low pregnancy risk can choose if they would like to deliver at home or in hospital with their midwife ("polyclinic birth"). Thus, there are many women who never see a doctor throughout their pregnancy and delivery (Kaminska 2015).

The basis for this system was laid out in the 1865 Dutch Practice of Medicine Act when midwives were established as independent medical practitioners. In 1941 the Health Insurance Decree established the monopoly (*primaat*) of midwives over normal ("low-risk") pregnancies. The risk selection was formally established in 1973 when the first official Dutch List of Obstetric Indications was published (Amelink-Verburg, Buitendijk 2010). The list has been revised three times (1987, 1999, and 2003) by an expert group consisting of midwives and obstetricians. In 2008, the European Perinatal Report suggested that the infant mortality rate has declined at a slower rate in the Netherlands than in other European countries (EURO-PERISTAT et al. 2008). This result constituted a shock to the Dutch maternity care system. The results were reconfirmed by the second report in 2008. Since then, the Netherlands has had an intense discussion on the quality of its maternity care system with a strong involvement of the media and parliament (Vos et al. 2016). In 2009, the Steering Committee Pregnancy and Childbirth published their report "A good start" which suggested that better interprofessional collaboration was necessary to improve quality and safety of the system. As a result, the Dutch maternity care system has changed towards an "integrated model of care" (Perdok 2017).

Germany: maternity care policy

Maternity care in Germany has shown more historical dynamic than in the Netherlands. While midwives were primary, distinguished and autonomous caretakers until the 19th century, they had lost this position by 1900 (Hakemeyer, Keding 1986). In 1923 and 1925 their position was improved by the right

of establishment and the inclusion of midwifery services in the public health insurance system. A major shift occurred under the Nazi regime which established midwives as the primary caretakers for normal births. Since then this law requires midwives to be present at all births and thus doctors need to call midwives to a birth except for emergencies, while midwives can perform births alone. In 1965, women received the right to prenatal care from doctors and in 1968 hospital births without a medical risk were included into the benefit basket of public health insurance. With this development the role of physicians and hospital births increased dramatically. The role of midwives was strengthened again in 1985 when they received the right to be self-employed and extend their range of services to prenatal and postnatal care (Schroth 1985). These services were then also covered by the public health insurance system. Since the 1990s, maternity care in Germany has been occupied with three main issues. First, quality and safety in maternity care are an ongoing issue that also splits professional organization and politics in terms of the right to births outside of hospitals (Reibling, Mischke 2015). Second, midwifery care particularly in the prenatal and postnatal period has received wide acceptance and support also from gynaecologists and obstetricians. However, there is an increasing shortage of midwives available to provide these services (Villmar et al. 2020). Finally, there is a trend towards the professionalization of midwifery. Effective 2020, midwifery has been transferred from a vocational training towards a university program (Plappert et al. 2019). The aim of this professionalization is to both contribute to higher quality and safety but also to increase interest in midwifery to solve the problem of midwife shortages.

Choice in care policies

Choice in Dutch childcare policy

Dutch family policy today is a pluralistic system, which is marketized and cost-intensive for high-quality care. The system aims at giving families choice, but also implies that much of the economic responsibility is carried by families too. While low-income families do receive childcare subsidies, these are not enough to cover flexible higher-cost formal childcare arrangements, thus restricting these families' choices. Furthermore, because formal parental leave is temporally limited with no statutory parental leave benefit, choice over work-care arrangements is restricted. Not least, leave schemes are based on individual planning and saving, rather than being granted as a right.

Is there a development towards more choice in the Dutch childcare policy?

Choice is an important principle underpinning Dutch family policy, especially in regard to care. The free choice narrative was used extensively in the political debates of the 1980s and 1990s in the Netherlands, but here choice meant that responsibility for family issues was shifted to the parents: parents should bear the consequences of their choices, not the Dutch state (Knijn 2008). When it comes to the question whether it has become possible for parents to exercise choice over how to organize childcare, a look at the content of the policy reforms is instructive. It then appears that choice in Dutch care policy means marketization – parents can make choices about their care arrangements as 'consumers' (Knijn, Lewis 2017; Morel 2007). However, given the absence of legal rights to parental leave, actual choice remains contingent on access to economic resources.

What are the drivers of choice in Dutch childcare policy?

The key drivers of choice in Dutch childcare policy have been political and economic motives, but cultural aspects arguably also played a role. First, politically, the Dutch 'welfare state crisis' in the 1990s has generally led to a decentralization of state provision, which included strengthening markets and communities. The aim was to lower welfare state 'dependence' by reducing state intervention, strengthening the role and responsibility of communities and employers. Second, macroeconomic arguments motivated the state to scale down their intervention in childcare during the same period. The welfare state was seen as too expensive, and one way to reduce state expenditure was to increase women's employment rather than allowing them to stay at home for childcare. The parental sharing ideal culturally legitimized female employment while sticking with the care-at-home orientation. Last, according to Kremer (2002), a further driver of choice in the Dutch childcare policy debate has been that choice is an important concept in the context of a religiously heterogeneous society and a pluralistic party system (pacification and consensus building).

Choice in German childcare policy

In the German childcare policy narrative, choice between alternative caretakers has overall played a less dominant role compared to the Dutch context. It did feature as an argument in political debates surrounding motherhood ideals. Here, it was however most prominently used to legitimize policy initiatives cementing traditional motherhood ideals, rather than allowing greater freedom for mothers to pursue careers.

Is there a development towards more choice in German childcare policy?

In terms of actual choice between different alternatives for care arrangements, policies introduced in the 2000s did lead to increased choice. The reforms included policies aimed to improve family-employment reconciliation for mothers, policies supporting families financially, and policies intervening in the traditional gender division of care. For example, the government's childcare expansion initiatives of the 2000s provided more factual choice for parents in increasing the availability of formal childcare (Leitner 2019). Further, the parental leave reform of 2007 included elements for improving mothers' labour market attachment as well as leave rights reserved for co-parents, strengthening choice in the division of care work between parents (Bünning 2015; Trappe 2013). Both reforms have however been suspected to primarily benefit higher-income families (Henninger et al. 2008; Krapf 2014). Likewise, Menke and Klammer (2017) argue that the paradigmatic turn in German family policy increased choice selectively for better-resourced families but not for marginalized ones. They suggest that the new model will perpetuate old socioeconomic divides or even create new inequalities.

What are the drivers of choice in German childcare policy?

The political debates around the family policy reforms in the 2000s in Germany contained some narratives of increased choice for families, although economic and demographic motives dominated (e.g. Rürup, Gruescu 2006; BMFSFJ 2006). The economic motive aimed to increase women's labour market participation, and the demographic motive aimed to incentivize family formation in light of falling birth rates. Both were used to legitimize the paradigmatic reforms. In the debates around care allowance (*Betreuungsgeld*) and care leave (*Familienpflegezeit*), on the other hand, mothers' choice was used as an explicit argument (Auth 2012). The conservative-liberal coalition promoted choice as important for family wellbeing, and the Christian Social Union (CSU) even used care allowance policy as a unique political selling point (Auth 2012). The policies introduced a cash benefit targeting people with care responsibilities for young children who did not make use of public childcare (*Betreuungsgeld*) and for

people caring for other (mainly elder) persons in need of care (*Familienpflegezeit*). It was argued that carers, and particularly mothers, should be able to choose to stay at home with their children, if they preferred that over following economic necessity to participate in the labour market. This argumentation assumed a prevailing norm that mothers should be the primary carers. It also framed employment as an economic necessity that women should be able to circumvent or postpone if possible, rather than as a career option or possibility for self-realization.

Choice in the Dutch maternity care policy

Women with a low-risk pregnancy in the Netherlands have the choice between a home and a polyclinic birth. In the case of a polyclinic birth, women deliver their baby in the hospital with their midwife, but leave the hospital a number of hours after the birth. Technically, women cannot choose to have a hospital birth under supervision of an obstetrician if their risk status does not indicate that this is necessary (Kaminska 2015). However, currently 60% of pregnant women in the Netherlands are considered high risk. There is also limited choice in access to pain relief. Only 10% of Dutch women have an epidural. Women are sent home as fast as possible which works well because they have a home care service (*Kraamverzorgste*) which is more extensive than the German midwife home visits, because these maternity assistants not only care for mother's and child's health and support breastfeeding, but also help with housework and caretaking of other children (older siblings).

Is there a development towards more choice in the Netherlands?

"This independence gives greater freedom to birthing women: whereas women in most other high-resource countries must struggle to organise a birth at home, women in the Netherlands have an easy choice of where their babies will enter the world: home, birth centre, polyclinic, or hospital" (De Vries et al. 2013, S. 1122). From the perspective of other countries and particularly women and movements who support a birth free of medical interventions and technology for low-risk women, the Netherlands are a model country of free choice in birthing (De Vries 2001). Because all methods of birthing are widely used in this country, they are regularly available to women and not as in many countries only to those who can pay, bargain or live close enough. This unique situation in the Netherlands is due to an institutional system and a strong midwifery profession that have actively protected a physiological, natural birth as the standard form of delivery (Benoit et al. 2005).

However, since the system is based on a risk assessment and selection by midwives – the primary assignment of women to primary and secondary care is in fact not a matter of a women's choice, but a professional decision. While this professional decision is uniquely performed by the midwife and not the doctor, it is not placed in the hands of the pregnant woman.[1] This practice has constrained choice: It can constrain choice for low-risk mothers who would prefer a birth in secondary care. Moreover, it has increasingly constrained the choice of high-risk mothers who now constitute the wide majority of pregnant women to deliver outside of the hospital.

What are the drivers of choice in Dutch maternity care policy?

In general, the unique maternity care system in the Netherlands has been explained by cultural factors (De Vries 2001). In this sense, the changes in choice can be conceptualized as a result of changing cultural factors which among other things come from an increased diversity of pregnant mothers who no

[1] Here and in what follows, we speak of pregnant women, since this is the most common case, while obviously there are pregnant persons who belong to other gender categories.

longer all value the traditional home-based, midwife-led maternity care system (De Vries et al. 2013). There is certainly also an important institutional component in the development of choice in maternity care. The Dutch healthcare system is itself based on a strong gatekeeping system between primary and secondary care. In this sense, maternity care mirrors the healthcare system arrangement. An analysis of the establishment of the gatekeeping system of midwives has shown that intraprofessional conflicts and transprofessional alliances were responsible for the establishment of the system (Goodarzi et al. 2018) and should thus be considered as a third important driver.

The most recent changes the system has experienced (since the mid-2000s) can also be associated with two distinct events. First, the publication of the EURO-PERISTAT reports can be considered as an external shock to the maternity care system that has called into question the social acceptance of a specific model of maternity care which was also based on limiting women's choices. With this window of opportunity open, narratives of choice and women's autonomy have become more important in the Dutch maternity care system (De Vries et al. 2013). Second, in 2006 the Netherlands underwent a complete restructuring of its healthcare system from a social insurance to a private health insurance system. This transformation was also accompanied by new developments in the choice of maternity care, e.g., the option to deliver with a gynaecologist based on personal wishes and not risk assessment (De Vries et al. 2013).

Choice in German maternity care policy

Women giving birth in Germany have a wide range of legal choices (Reibling, Mischke 2015). They have a right to prenatal, interpartum and postpartum care. They can choose their specific provider and decide whether prenatal care is provided only by a doctor or also by a midwife. It is possible to have a home birth, a birth in a birth centre or in a hospital. Choice is restricted if there are risk indications which require women to deliver their baby in a hospital. Despite this formally generous range of choices, choice is restricted in Germany by the low and decreasing number of midwives available in urban areas and a general shortage of midwives who offer births outside of hospital (Albrecht et al. 2019). Moreover, most women in Germany have a regular gynaecologist for contraception and cancer screening visits, which establishes a specialist provider as a first point of contact during pregnancy. General practitioners do not play any role in the German maternity care system (Reibling, Mischke 2015).

Is there a development towards more choice in the German maternity care system?

Considering changes from 1950 until now, choice has certainly been extended in the German maternity care system. Today, women in Germany legally have a wide range of choices: they can decide who provides prenatal care (midwife or doctor) as well as the place of birth (home, birth centre, hospital). Legally, women also have the right to decide about the medical interventions, mode of birth and use of pain medication (unless the life of the child is in danger). However, in terms of the existing discourse and practice, the focus in the last 10 years has been on limited choices that come from a low number of midwives and particularly midwives who provide home or birth centre births. Similar to the Netherlands and other advanced, industrialized countries, the number of pregnancies considered as high risk is increasing and choice for this group is limited – particularly to deliver a child outside of hospital.

What are the drivers of choice in German maternity care policy?

Professional organizations, particularly midwifery associations, have pushed the political debate in recent years. They have used "securing access to non-clinical births" and thus choice as a narrative to

strengthen their position in the German maternity care system. Consumer organizations and women's movements on childbirth have not been strong advocates compared to their role in some Anglo-Saxon countries. Nevertheless, the formation of a committee on midwifery care in Germany was stimulated through a "future dialogue" campaign of the German chancellor in which citizens and experts identified the future of midwifery care as one of the most pressing topics for Germany. Public health researchers and institutes (e.g. *Bundeszentrale für gesundheitliche Aufklärung*) have also been active players in recent debates and have particularly drawn attention to how existing choices and limitations create inequalities and negative social and health outcomes for vulnerable groups (Kooperationsverbund gesundheitsziele.de, BMG 2017). In comparison to the Netherlands, it is also important to draw attention to the German healthcare system which, in contrast to the Netherlands, places high value on choice and where access to specialist care is much less regulated than in most other advanced, industrialized countries (Reibling, Wendt 2012).

Conclusions and outlook

The comparison of the two countries in terms of the role of choice in the two care policy areas suggests similarities but also rather glaring differences, both across countries and across policy areas. Both countries have seen some sort of development towards increasing choice, which was related to economic reasoning (in childcare policy) and risk assessment (in maternity care policy). But it is also clear that the expansion of choice has taken place on different levels with significantly less choice in the Netherlands and stronger developments in Germany in both policy areas. For Dutch childcare policy, choice has meant marketization, self-responsibilization and employer involvement. In Germany, by contrast, the development was towards state-supported individualization, or optional familism. In Dutch maternity care policy, choice has meant more medicalization. While in Germany, increased choice in maternity care means more involvement of midwives (particularly in prenatal and postnatal care), but with little quantitative significance in terms of place of birth.

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