Selection procedures in Dutch Obstetrics

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One of the characteristics of obstetric care in the Netherlands is a system of prenatal sèlection by which two groups are formed: without and with an increased risk, in other words a potental physiological and non-physiological group. For the first group the possibility of home delivery exists in the Netherlands; this is a decreasing but still quite a large group (1978: 36%). The efficiency of the selection procedure is very important, to assess this efficiency three question have to be anwered:

1. What is the adherence to the generally recognised selection criteria,
2. What is the value of individual selection criteria (risk factors),
3. Is the result of the selection procedure a proper subdivision in risk groups.

To answer these questions a region in the Netherlands, the region of Enschede was studied during one calendar year (1974). In that year deliveries took place at home, in hospital and in a maternity centre; obstetric assistance was given by general practitioners, midwives and obstetricians. Prospective obstetric and neonatal data were collected on all birth within an area of 165.000 inhabitants, just over 2.000 babies were included.

From this study it was concluded that application of the selection criteria was not very consistent: about one third of the women in the group of not-primarily planned hospital deliveries should not have been in that group any more at the beginning of labour. On the other hand quite a number of women in the group of primarily planned hospital deliveries didn't have any risk factor at all or only a risk factor of questionable significance.
Individual selection ciriteria, risk factors, as they are used in the Netherlands, proved their value. Prematurity and dysmaturity to be regarded as perinatal morbidity as such, appeared to determine, by their incidence and relative risk, perinatal mortality to a large extent. As many cases are potential preventable, proper application of selection criteria and the decision about the right place of birth seems to be very important. Primiparity, not recognised in Holland as a selection criterium, appeared a factor of some importance in relation to perinatal mortality and prematurity. Also the chance that a primiparous woman is refered during pregnancy or delivery is considerable: the group of secondary hospital deliveries is mainly composed of primiparous women.
Due to the non-optimal primary selection the results in different subgroups is not as expected, this is shown in the next table:

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Perinatal mortality and morbidity in primarily planned hospital deliveries (1), not-primarily planned hospital deliveries (2+3), secondary hospital deliveries (3) and physiological group (2).

group	:	(1)	(2+3)	(2)	(3)
n	=	619	1416	835	581
perinatal mortality	%	2,4	2,6	0,2	5,9
dysmaturiy	%	9,3	10,3	7,7	14,6
prematurity	%	8,8	7,6	4,0	13,4

The incidence of perinatal mortality, dysmaturity and prematurity in the group of primarily planned hospital deliveries does not differ from the incidence in the group of not-primarily planned hospital deliveries. As might be expected, perinatal mortality and morbidity is high in the group of secondary hospital deliveries. Unexpected high is the incidence of perinatal morbidity in the group that delivered at home or in a maternity centre.

This study showed that the present selection procedure in the Netherlands does not meet all the requirements; this is caused by (1) the subdivision in only two groups (hospital deliveries and the "physiological group") and by (2) the fact that adherence to generally recognised risk criteria proved to be difficult. Improvement can be achieved by a subdivision in more than two risk groups and by a closer cooperation between midwives, general practitioners and obstetricians.
Preservation of selection procedures is necessary in order to avoid a waste of obstetric care (too many low risk deliveries under high care) or bad obstetric care (too many high risk deliveries under low care).

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