3.3. Gynaecologists and obstetricians, and midwives

Gynaecologists are concerned with the functions and diseases affecting the female reproductive system, while obstetricians specialise in pregnancy and childbirth. A doctor will often specialise in both these areas, and the data reported in this section does not distinguish between the two. Midwives provide care and advice to women during pregnancy, labour and childbirth and the post-natal period. They deliver babies working independently or in collaboration with doctors and nurses.

In countries with a medicalised approach to pregnancy, obstetricians provide the majority of care. Where a less medicalised approach exists, trained midwives are the lead professional, often working in collaboration with general practitioners, although obstetricians may be called upon if complications arise. Regardless of the different mix of providers across countries, the progress achieved over the past few decades in the provision of pre-natal advice and pregnancy surveillance, together with progress in obstetrics to deal with complicated births, has resulted in major reductions in perinatal mortality in all OECD countries.

In 2011, the number of gynaecologists and obstetricians per 100 000 women was the highest in the Czech Republic and Greece, followed by Italy and the Slovak Republic (Figure 3.3.1). These are all countries where obstetricians are given a primary role in providing pre-natal and childbirth care. The number of gynaecologists and obstetricians per 100 000 women was the lowest in New Zealand, Canada, Ireland, Chile and the Netherlands.

Since 2000, the number of gynaecologists and obstetricians per 100 000 women has increased in most countries, although the growth rate varied (Figure 3.3.1). It was highest in Mexico, Australia, Switzerland and the United Kingdom. On the other hand, the number of gynaecologists and obstetricians per 100 000 women declined slightly in Japan and the United States. In the United States, this was because the growth in the population number exceeded the growth in the number of gynaecologists and obstetricians.

The number of midwives per 100 000 women was highest in Iceland, Sweden, Turkey and Australia in 2011 (Figure 3.3.2). It was the lowest in Korea, Canada and Slovenia. While the number of midwives has increased significantly in Canada and Slovenia over the past decade, it has fallen in Korea. This decline has coincided with a continued reduction in fertility rates in Korea. The number of midwives per capita also decreased slightly in Estonia, Hungary and Israel between 2000 and 2011. In Hungary, most of the reduction occurred between 2006 and 2007, as the number of beds in maternity wards was cut by more than one-third in the context of a health reform. In the Netherlands, the number of midwives has increased faster than the number of gynaecologists and obstetricians, and the number of births in hospitals attended by midwives rose from 8% in 1998 to 26% in 2007 (Wiegers and Hukkelhoven, 2010).

The relative mix of providers has both direct and indirect implications for the costs of pre-natal and natal services. Services involving midwives are likely to be cheaper. This reflects in part the lower training time and hence a lower compensating pay for midwives in comparison to gynaecologists and obstetricians. In addition, obstetricians may be inclined to provide more medicalised services. A study of nine European countries found that the cost of delivery is lower in those countries and hospitals that employ more midwives and nurses than obstetricians (Bellanger and Or, 2008).

There is little evidence that systems that rely more on midwives are less effective. A review of a number of studies finds that midwife-led models of care resulted in fewer complications (Hatem et al., 2008). Another review found that midwives are equally effective in providing pre-natal care and advice in the case of normal pregnancies (Di Mario et al., 2005), although support from obstetricians is required for complications.

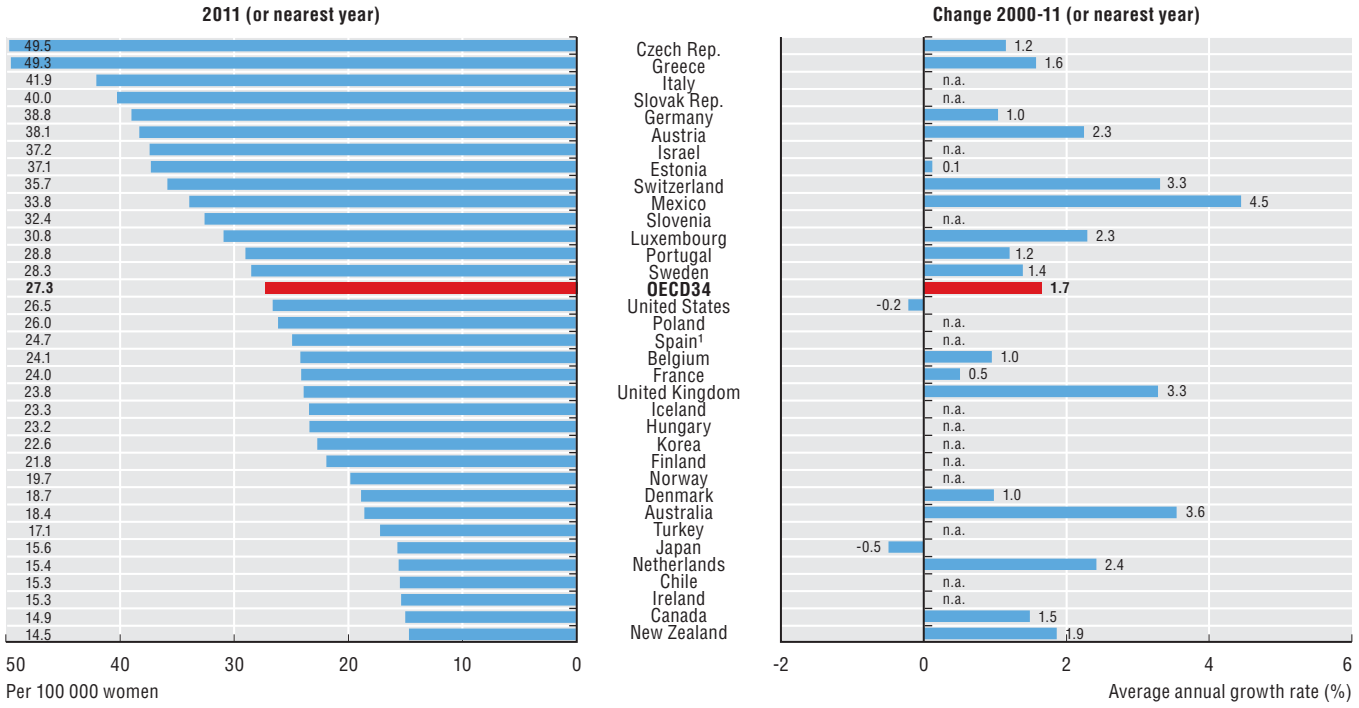
Definition and comparability

The number of gynaecologists and obstetricians combines these two specialities.

The figures for gynaecologists and obstetricians, and for midwives, are presented as head counts, not taking into account full-time or part-time status (except in Ireland where the data on midwives are based on full-time equivalents). In Spain, the number of gynaecologists and obstetricians only includes those working in hospital.

The number of midwives in Canada may be underestimated, as they may undercount the number of midwives in provinces/territories where there is no regulation requiring licensure as a condition of practice. In Austria, the number of midwives only includes those employed in hospital (resulting in an underestimation of 40 to 50%).

3.3.1. Gynaecologists and obstetricians per 100 000 women, 2011 and change between 2000 and 2011

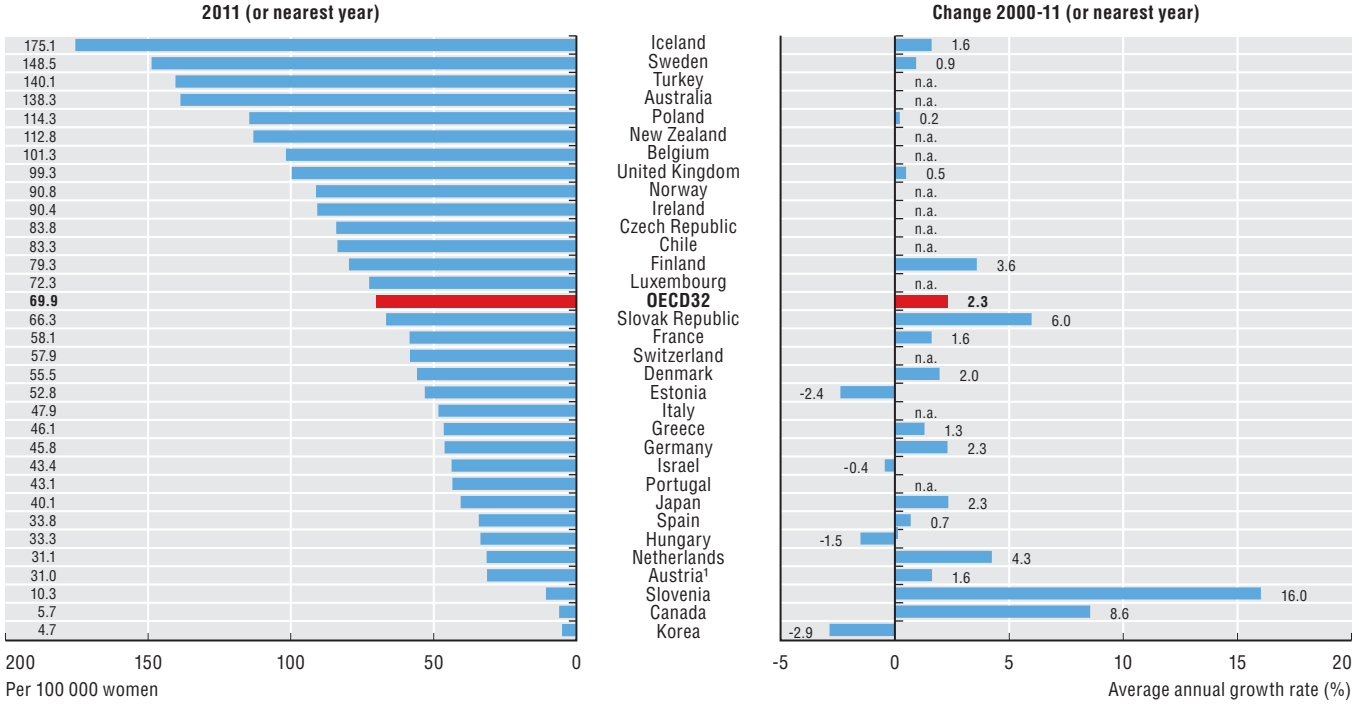


1. In Spain, the number of gynaecologists and obstetricians only includes those working in hospital.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888932916895

3.3.2. Midwives per 100 000 women, 2011 and change between 2000 and 2011



1. In Austria, the number of midwives only includes those working in hospital.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888932916914

From:

Health at a Glance 2013

OECD Indicators

Access the complete publication at:

https://doi.org/10.1787/health_glance-2013-en

Please cite this chapter as:

OECD (2013), "Gynaecologists and obstetricians, and midwives", in *Health at a Glance 2013: OECD Indicators*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/health_glance-2013-25-en

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