BRITISH COLUMBIA CENTRE
OF EXCELLENCE FOR WOMEN'S HEALTH

POLICY SERIES

Solving the maternity care crisis

MAKING WAY FOR MIDWIFERY'S CONTRIBUTION

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Canada's Crisis in Maternity Care

Although Canada has one of the lowest maternal-infant mortality rates in the world,[1] our maternity care environment is in crisis. The attrition rate for physicians who provide maternity care is high and it is becoming increasingly difficult to attract new practitioners to the specialty because of its demanding lifestyle, practitioners' fears about litigation, and inadequate pay.[2] Today less than half of the family physicians in Canada offer maternity care to their patients. At a national conference to address this crisis, doctors and nurses stated that "Pregnant women and their babies are increasingly put at risk because access to appropriate care is compromised."[3]

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Percentage of Family Physicians & General Practitioners Delivering Babies in Canada, by Province [4]

Newfoundland	15.3%	Ontario	12%
Prince Edward Island	11%	Manitoba	24.4%
New Brunswick	22.8%	Saskatchewan	40.5%
Nova Scotia	24.7%	Alberta	32.1%
Quebec	7.4%	British Columbia	30.6%

Rural and remote areas are particularly affected by the practitioner shortage, endemic to all rural health care practitioners, which is caused by burnout and the centralization of hospitals and other health care services in cities.[5,6,7] Women who are poor, periodically homeless, suffer from mental illness, or are addicted to substances may suffer additional consequences from the practitioner shortage due to their greater maternity care needs.

Midwives attend 5% of the births in provinces where midwifery is regulated and 2% nation-wide. Although the demand for midwifery care across Canada is high – most practices in urban areas report waiting lists and rural communities without services are vying for midwives – only 400 midwives are registered to practice. Few spaces in midwifery education programs mean there are not enough new graduates to bolster these forces significantly.[8] In contrast, in New Zealand

(population 3.98 million)[9] there are over 2,000 midwives, over 70% of births are attended by midwives and education programs produce 80 to 100 new graduates each year.[10] In England, similar rates of midwifery care as New Zealand suggest that the profession in Canada could potentially make a much greater contribution to maternity care than is presently the case.[11,12]

Midwifery's Contribution to Maternity Care

Country	Number of Registered Midwives	% of Total Births Attended by Midwives	Year
Canada	400	2%	2002
New Zealand	2,018	70%	2002
England	5,744	72%	2002

New policies are needed at the provincial and federal government levels to enhance the capacity of midwifery to help solve the practitioner shortage.

Due to the low rates of maternity care provided by family physicians and midwives in Canada, obstetricians are currently attending the majority of low-risk pregnant women. This leads to increased costs and under-utilization of high-level skills and training. This can be addressed by supporting family physicians and midwives to better meet the needs of Canada's childbearing population. As the need increases for physicians to attend to many aspects of primary care, in addition to or to the exclusion of maternity care, the profession of midwifery, with its single focus, is ideally positioned to meet demands for maternity care.

Although recent reports on the future of health care in Canada address the shortage of health care professionals, midwifery is not mentioned as a way to increase the numbers of maternity care providers.[13,14] New policies are needed at the provincial and federal government levels to enhance the capacity of midwifery to make a greater contribution to maternity care and to help solve the practitioner shortage.

The Canadian Midwifery Model of Care

Midwifery is regulated and funded in four provinces (Ontario, British Columbia, Manitoba, and Quebec) and regulated but not publicly funded in Alberta. Midwifery contributes to the care of low-risk birthing women in Canada. The model of care is based on principles of:

- informed choice and informed consent;
- choice of birthplace;
- evidence-based practice;
- respect for normal birth;
- continuity of care; and
- judicious and appropriate use of medical technology.

Midwives provide comprehensive and holistic prenatal and post-partum care. Thus they are well positioned to care for socially vulnerable populations who may benefit from increased social support during the childbearing year.

Making a Greater Contribution: What's in the Way?

Limited access to midwifery care, conditions that threaten the sustainability of midwifery, and obstacles to inter-professional collaboration among maternity care providers are specific challenges that, if not met, will restrict midwifery's capacity to meet the needs of childbearing women in Canada.

Limited Access to Care

a. Regional Inequities

Publicly funded midwifery care is only available in Ontario, British Columbia, Manitoba, and Quebec (where the scope of practice permits midwives to attend births in birthing centres only). This leaves women in all other jurisdictions without access to midwifery care or reliant on unregulated private midwifery care, which is too costly for many women with specialized social needs who might benefit from it the most.

b. Human Resource Shortages

Despite a scope of practice conducive to providing care for 80 to 90% of Canada's childbearing women, midwives currently attend approximately 5% of the births in provinces where they are regulated and 2% nation-wide. Many practices have waiting lists and many women who would like to receive care from a regulated midwife are unable to do so. This is due to the newness of regulated midwifery and the lack of time midwifery has had to increase its membership. Another factor that contributes to a slow professional growth rate is the limited number of spaces available in midwifery educational programs. For example, in British Columbia there are only ten seats available per year in the four-year midwifery program at the University of British Columbia. Approximately 70 new midwives graduate in Canada each year. The lack of funding for Prior Learning Assessment and English as a Second Language programs specific to midwifery is a barrier to foreign-trained midwives. In jurisdictions where these programs are available, they have contributed to the successful assessment and registration of these midwives.

c. Rural – Urban Inequities

Midwifery practices across Canada are clustered in and around large cities. In rural and remote areas, midwives face similar challenges as other local health care providers. They must contend with limited access to specialists, diagnostic technologies, peer support and continuing medical education, and they

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often practice in isolation. This leads to burnout and a high attrition rate.[15] In instances where resources are severely limited, midwives must curtail their practice because of inadequate provisions for back up by physicians and health services for emergencies.

d. Inequity in Aboriginal Communities

Aboriginal midwives in Canada have had a long history of supporting women in their communities through pregnancy, labour, and birth in ways that honoured cultural traditions and beliefs.[16] Their practice predates the midwifery that began with the arrival of settlers. Many events lead to the dissolution of traditional Aboriginal midwifery, including colonialism, the larger culture's adherence to western medicine, residential school systems and policy changes that undermined many Aboriginal health traditions.[16] Currently there is a resurgence in some Aboriginal communities to bring the birthing process back into the community as part of indigenous healing practices. Despite initiatives to return control of childbirth back to Aboriginal women and their communities, however, few Aboriginal midwives have registered with provincial colleges.

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Midwife

To watch – to care **COAST SALISH** *Women's helper* **CHILCOTIN**
She who can do everything **NUU-CHAL-NULTH** [16]

Obstacles to the Sustainability of Midwifery

a. Inadequate Remuneration

Although payment methods for midwives vary between jurisdictions, midwives report that their rate of pay is inadequate to meet costs of supplies, overhead, and fees.[17] Midwives in rural and remote communities incur the additional expenses of travel to attend professional meetings and continuing education workshops, sometimes supported by a lower annual income than urban midwives earn due to a smaller client load. The need to meet expenses can lead to less time off and further contribute to professional burnout.

Fee for service payment in Ontario and British Columbia limits the ability of midwives to provide care for populations whose needs may exceed those supported by the current model of care. For example, women with substance use issues or teenage mothers may need longer or more frequent appointments in the prenatal and post-partum period: the number of clients a midwife can serve, and bill for, is therefore reduced. Manitoba has met this challenge through salaried payment.

b. **Inflexibility in Practice**
Due to financial concerns and active practice requirements (the number of births midwives must attend to ensure their skills are current), part-time practice is not feasible for many midwives in most jurisdictions. The imperative for full-time practice precludes the contributions of many skilled midwives who have elected to work part-time due to family commitments or for health reasons.

c. **Scope of Practice**
Midwives in Ontario, British Columbia, and Manitoba have a full scope of practice with the potential for hospital admitting privileges and specific diagnostic and prescribing rights. In Quebec, midwives may attend births in birthing centres only. Midwives are beginning to discuss added skills and competencies that may be beneficial to birthing women, especially in rural and remote areas. The potential for second-assisting caesarian sections, performing vacuum extraction, well women gynecology, including prescribing oral contraceptives and carrying out pharmacological induction of labour in some instances, are a few examples of an expanded scope that would benefit both maternity care and the community.

The common skill set among midwives and other maternity care professionals is conducive to developing an inter-professional collaborative curriculum.

Obstacles to Inter-professional Collaboration

a. **Lack of a Collaborative Curriculum**
Midwives in Canada are trained through university-based midwifery education programs, and in Manitoba alone through apprenticeship models. Although individual classes may be offered in conjunction with other faculties within health sciences, many are still exclusive to midwifery students. The common skill set among midwives and other maternity care professionals, such as physicians and obstetrical nurses, is conducive to developing an inter-professional collaborative curriculum. Aside from the added efficiency, this would help develop a common understanding between the professions and lay the ground for future collaborative relationships.

b. **Limited Interdisciplinary Models of Care**
Regulated midwives provide primary care to women during the childbearing year as autonomous practitioners. They may work in conjunction with family practitioners if a client has a pre-existing medical condition and will consult with obstetricians and other specialists as needed. However, as a nascent profession that has struggled to distinguish itself from nursing and remain autonomous vis-à-vis medicine, midwifery has engaged in little inter-professional collaboration to date. This is changing, but at a slow rate. Some midwives and family physicians are recognizing the similarities in their philoso-

phy and style of practice and provide back up for each other and share call schedules. This is especially advantageous given the human resource shortages in maternity care.

Policy Recommendations: Making Way for Midwifery's Contribution

1. More than half of the provinces in Canada do not have legalized, regulated, funded or integrated midwifery care. Most regulated midwifery care takes place in urban areas. The federal government must take a leadership role to promote and encourage universal access to publicly funded midwifery care in Canada.
2. Educational programs are essential to ensure the continued growth of midwifery in Canada. Provincial and territorial governments must ensure adequate funding is available for educational programs.
3. Provincial governments should increase the annual intake of students in midwifery education programs and consider ways to shorten the education program for appropriate students.
4. Provincial governments should prioritize the development and funding of Prior Learning Assessment programs for midwives who trained in other countries.
5. Provincial governments should provide subsidies for midwives practicing in rural and remote locations.
6. Both federal and provincial governments should take an active role in enhancing the capacity of Aboriginal midwives to meet the needs of women within their communities who would like midwifery care. This should be done through supporting communities to:
   - identify and reclaim traditions and beliefs about birthing;
   - bring the birth process back to the community;
   - train local women as community midwives through formal or apprenticeship models; and
   - develop local birthing centres.
7. Provincial governments should offer greater flexibility in models of remuneration. This is crucial to attract midwives to rural and remote locations and to meet the needs of vulnerable populations. Funding arrangements should include:
   - stipends for rural and remote practitioners;

The federal government must take a leadership role to promote and encourage universal access to publicly funded midwifery care in Canada.

- paid leave for professional development and continuing medical education; and
- flexibility in models of payment to accommodate care to vulnerable populations with specialized needs.

8. To help facilitate the contributions of midwives with young families and midwives who, for health or other reasons, choose to work part-time, provincial colleges must insure flexibility in their practice requirements and models of care.

9. With an expanded scope of practice, midwives would be able to meet the needs safely and effectively of a larger portion of the low-risk childbearing population. These changes should be determined by dialogue between professional associations and provincial colleges and their members.

10. Provincial governments should encourage and support interdisciplinary curriculum development for students in midwifery, medicine, and nursing.

11. Provincial governments should encourage and support inter-professional teams made up of midwives, physicians, and obstetrical nurses where such collaboration would clearly benefit the needs of the population served.

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Notes

1. According to United Nations statistics, Canada currently has the 5th lowest infant mortality rate. United Nations. The world's women 2000: Trends and statistics. Life expectancy and infant mortality (n.d.) [cited 2003 Jan 12].
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