“You can’t just be a little bit pregnant”
A System’s view of Midwifery Policy and Practice across Canada
Overview

- What are midwives & how do they practice in Canada
- What is the state of midwifery legislation & education across Canada
- Economics of midwifery
- Place of birth/Place of work
Canadian Midwifery

- Canadian midwives are primary health care providers who care for women during pregnancy and birth and up to six weeks postpartum (Canadian Institute for Health Information, 2010).

- Midwives are experts in “protecting, supporting, and enhancing the normal physiology of labor, delivery, and breastfeeding” (Rooks, 1999, p. 370).
Model of Midwifery Care

- All registered midwives in Canada are primary care providers who typically work in groups under the following criteria (CMRC, 2014b):
  - Continuity of care
  - Duration of care
  - Choice of birth place
  - Quality of care
  - Continuity of care throughout labour and delivery
  - Transfer of care to a physician
<table>
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<tr>
<th>Province/Territory</th>
<th>Legislation/Regulation</th>
<th>Public funding</th>
<th>Employment Status</th>
<th>Remuneration</th>
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# Midwifery Education (2011)

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<tr>
<td>Université du Québec à Trois-Rivières</td>
<td>4.5</td>
<td>B. Sc</td>
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Manitoba’s Cautionary Tale

• A case of stalled development, largely because of the lack of an education program – Thiessen 2014

• Projected targets*:
  • By 2005 need: Approximately 140 practising midwives in province

Actual numbers as of 2010:
• 38 practising midwives
• Midwifery-attended births = 5%
• No graduates from University College of the North
New Brunswick

- Stalled implementation

- Midwives were argued to be a **costly add-on to the system** - costing at least $760,000

- Typical ‘back of the envelope’ economic analysis
Economic of Midwifery

• *White Coat, Black Art* September 2014

“Just once I’d like to be asked how costly it is **NOT** to have midwives”
The Case of Maternity Care (Ontario)

Data provided by Dr. Stanley Lofsky
(based on 1998/99 Provider Data)

- Family Physicians
- Obstetricians
- Midwives
What are the consequences?

- There are not enough midwives to take up the lack of family physician attendance; besides, family physicians tend to refer to obstetricians so more and more obstetricians are attending low-risk childbirth.
- Obstetricians are trained, and trained very well, in the care of women who have high risk pregnancies. But their ‘high-risk’ approach to care can result in more interventions being done on women for whom the interventions are less appropriate, less effective and less evidence based.
- From a system perspective, there is a growing mismatch in approach required and applied
HARRY BELIEVED IN HAVING THE RIGHT TOOL FOR THE WRONG JOB
Should obstetricians be attending low-risk birth?

- Obstetricians are trained to manage high risk pregnancies, which often require vigilance and intervention.
- Midwives are trained to manage ‘low risk’ pregnancies in a way that is vigilant but in a way that is less interventive; this can take time and patience.
  - The philosophy behind midwife-led care is a focus on normality and being cared for by a known, trusted midwife during labour
  - The emphasis is on the natural ability of women to experience birth with minimum intervention
Consequences?
Caesarian Section Rates *(Canada)*

**Canadian Caesarean Section Rates**
Except for a dip in the early 1990s, Canada’s caesarean section rate has increased in the last two decades. It reached an all-time high of 22.5% of in-hospital deliveries in 2001–2002.

![Graph showing caesarean section rates in Canada](image)

Top 5 reasons for inpatient surgeries in 2012–2013:

- **C-section delivery:** 100,686 surgeries
- Knee replacement: 57,829 surgeries
- Hip replacement: 47,297 surgeries
- Hysterectomy: 40,127 surgeries
- Coronary artery dilation: 40,074 surgeries
Myth: C-sections are on the rise because more mothers are asking for them

Fact: Clinical practice guidelines are not consistently implemented (Labour induction, VBAC, dystocia)
Development of MSH-CARES

Problem:
- Rising C/S and induction rates (25% in 2005; 29.7% in 2009/10) at MSH (Toronto, Central LHIN)
- Inappropriate inductions
- Very few women choosing VBAC despite high success rate

Context:
Increasing annual birth volume (10% increase in births from 2004/05 to 2011/12; 3100 births/yr)
No projected increase in funding
Evidence Based Interventions
MSH-CARES Targets and Outcomes
Promising Results

Annual Caesarean Section Rates (% of births)

For more information:
www.pushingforthebestchoice.ca
Cost of C-Sections

- C-sections are more costly than vaginal births, because they require more resources like operating room space, anesthesiologists and nursing care, as well as a longer hospital stay.
  - A C-section costs $4,600, compared with $2,800 for a vaginal birth (CIHI 2006).

- Pulling back the curtain on rising c-section rates: http://healthydebate.ca/2014/05/topic/quality/c-section-variation
Economic of Midwifery

- Evaluations of the specific model of care in Canada/Ontario found that midwifery care resulted in fewer obstetrical interventions compared to services provided to low-risk women by family doctors:
  - a 38% lower c-section rate,
  - 62% fewer instrument-assisted births,
  - double the number of women discharged within 48 hours of birth, and
  - lower maternal/newborn hospital readmission rates.
Economic of Midwifery

- Cochrane review:
  http://www.cochrane.org/reviews/en/ab004667.html

  - Midwifery care is associated with fewer instrument-assisted births, lower C-section rates, and reduced hospital stays (Hatem, Sandall, Devane, Soltani, & Gates, 2008).
  - most women should be offered midwife-led models of care
Economic of Midwifery

- Hospital-based midwife deliveries are reported to save the Ontario health care system $800 per birth and home deliveries to save $1,800 (AOM, 2007).
Place of Birth

- Midwifery in hospital & midwifery led hospital units

- Safety of Home births
  - CAM Position on Home Birth
    - “The best available evidence from North America and international studies demonstrates that midwife attended home births are associated with optimal labour and birth outcomes. Midwife attended planned home births in Canada are associated with fewer obstetrical interventions and no increase in maternal/fetal/neonatal mortality or morbidity compared to births planned to be in hospital.”

- The option of Birth Centres
Birth Centres

- Quebec
  - 17Maisons de naissance
- Ontario
  - Toronto Birth Centre
  - Ottawa Birth Centre
- Manitoba
  - Women’s Health Clinic
- Alberta
  - Arbour Birth Centre in Calgary
  - Lucina Birth Centre in Edmonton
## Aboriginal Midwifery Practices

<table>
<thead>
<tr>
<th>Name</th>
<th>Year Opened</th>
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<td>Inuulitsivik Health Centre, Nunavik</td>
<td>1986</td>
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<tr>
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<td>Cambridge Bay Birth Centre</td>
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<td><strong>Northwest Territories</strong></td>
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<td>Fort Smith Health and Social Services Midwifery Program</td>
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<td>Kinosao Sipi Midwifery Clinic, Norway House Cree Nation</td>
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<td><strong>Ontario:</strong></td>
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<td>Seventh Generation Midwives Toronto</td>
<td>2005</td>
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<td>Tsi Non:we Ionnakeratstha Ona:grahsta’ Six Nations Maternal and Child Centre</td>
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Place & Value of Work

- Must acknowledge start up costs – for a new profession and a new work locale

- Important to not cut costs in the system on the backs of midwives
  - What they do/don’t do
  - Not who they are

- Pay Equity/Retention
  - “Caring Dilemma”
“You can’t just be a little bit pregnant”

A System’s view of Midwifery Policy and Practice across Canada
For more information, copies of reports & update on progress please go to:

www.ivylynnbourgeault.com

Thank you