

PATIENTS FIRST



Leveraging Midwives to Strengthen Maternal and Newborn Primary Care in Ontario

Ontario midwives welcome the opportunity to provide input following the release of the MOHLTC's discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*.

We encourage the MOHLTC to include *maternal and newborn care* in its analysis and implementation of primary care reforms. This is critical given that health during pregnancy, birth and postpartum has lifelong effects and that primary care during pregnancy is often a patient's[†] entry point into the health system.

While important gains have been made in maternal and newborn health over the past decade, the delivery of maternal and newborn health services is not currently situated within primary care. Rather, highly trained specialist obstetricians provide the vast majority of care to low-risk clients and newborns in the hospital setting. Data from Ontario reflects this: obstetricians attend 84.7% of births, meaning that home birth is not an option for most Ontarians.

Over time, Ontario has built a system of care that is defined by high rates of interventions; care is hospital-based and the majority of patients, who are low risk and appropriate for primary care, access specialists. As primary care providers, midwives remain poorly integrated into the system and access to midwifery is compromised. It's a system rampant with medically unnecessary transfers of care due to unnecessary

restrictions on midwives' scope of practice, long lists of patients seeking midwifery who are unaccommodated and inadequate access for Aboriginal communities. Simply put, the current system is not patient-centred for most Ontarians.

An exciting opportunity exists, through the Patients First transformation agenda, to understand the current method of planning and delivering maternal and newborn services. Implementing changes to transform a system that is rooted in specialist care with high rates of intervention into one that is organized around community-based primary care, will best serve the needs of Ontarians in this formative health-care experience.

Specifically, that opportunity lies in leveraging midwifery. With low rates of intervention and excellent clinical outcomes, midwifery provides *primary care in partnership* with patients, in the community and with exceptional patient satisfaction.¹

In our submission, we briefly discuss the reforms that, over the last decade, have already had a positive impact on maternal and newborn care in Ontario. These reforms have laid a foundation from which to transform maternal and newborn care planning and delivery. We then look at the current system of planning and delivering services and the ways in which patients are not well served. Lastly, we make recommendations about how *leveraging midwifery* can bring better value and quality to Ontarians.

[†]We use the word "patient" in this submission deliberately to further the inclusion of maternal and newborn health into government's transformation efforts. However, we typically refer to patients as clients, since pregnancy and birth are not an illness or a disease but rather a (most often) a healthy life event.

A FOUNDATION FOR TRANSFORMATION

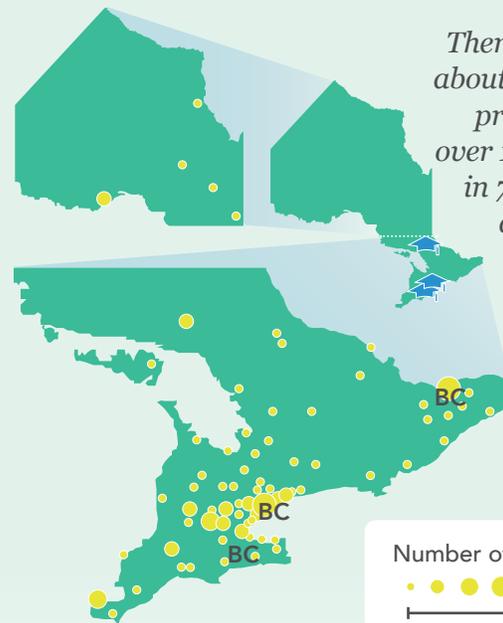
Ontario has made significant reforms to maternal and newborn care over the past decade.

The creation of **BORN** enables Ontario, for the first time, to collect complete data sets on birth and to utilize data to inform planning and service delivery. The Provincial Council on Maternal and Child Health (PCMCH) was recently tasked with developing a **low-risk maternal and newborn care strategy**.

Government investments, specifically in *midwifery infrastructure*, have laid a foundation for future reforms. Investments in education have increased the midwifery workforce.² Three university sites (Ryerson, McMaster and Laurentian) now graduate a total of about 80 midwives per year. There are currently about 800 practicing midwives. In 2014-15, midwives delivered more than 19,000 newborns and provided primary care to mothers or birthing parents.³ In 2014, Ontario added two midwifery-led birth centres located in Toronto and Ottawa, bringing the total number of birth centres to three.⁴ In 2012, Neepeeshowan Midwives,⁵ the first on-reserve midwifery practice group was established to provide care in Attawapiskat and surrounding coastal communities. In the 2015 provincial budget, funding was earmarked for supporting Aboriginal midwifery in Ontario, responding to calls from the Aboriginal community for “Aboriginal midwives working in every Aboriginal community.”⁶

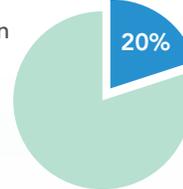
These improvements provide significant return on investment. Midwifery boasts exceptional outcomes;⁷ effective use of resources through low intervention rates; short lengths of stays in hospital;⁸ home and community-based care with 18.6%⁹ of midwifery births occurring out

There are currently about 800 midwives providing care to over 19,000 families in 75 communities across Ontario.



20% of midwifery clinics are in rural or remote communities

■ Rural
■ Urban



Number of midwifery clinics



➤ Midwifery education program

BC Birth centre

of hospital and early postpartum care provided in patients' homes; and excellent rates of client satisfaction.^{10,11} Midwifery delivers the right care, at the right time, in the right place and by the right provider.

Now is the time, as part of the proposed Patients First primary care reforms, to build on these successes. Maternal and newborn care must be thought of, and specifically included in, primary care reform.



GAPS IN MATERNAL AND NEWBORN CARE TODAY

MATERNAL AND NEWBORN CARE IS NOT PATIENT-CENTRED

Birth is the leading reason for hospitalization.¹²

1 in 3 patients give birth by C-section.^{13,14}

4 out of 10 patients cannot access midwifery.

98.5% of births in Canada take place in hospitals.¹⁵

Patient-centred care in the maternal/newborn setting should allow patient choice of provider and birthplace.

Despite the fact that most patients would thrive with a low-risk primary care provider (like a midwife or a family physician) during pregnancy, birth and postpartum, the vast majority of Ontarians are currently not able to access a primary care provider. Instead, care is largely delivered by specialist obstetricians. Below, we explore why a model of care delivered by specialists is not patient-centred.

Transformation that leads to a system where primary care providers care for patients, in collaboration with specialists who perform a critical consultant role, is the key to providing patient-centred care. The midwifery model, for example, puts patients first by: building a partnership with patients; providing continuity of care (so that the patient knows the provider attending their birth); judiciously using interventions; supporting high rates of chest and breastfeeding; supporting choice of birthplace and by following the patient from home to community to hospital as needed.

Limited access to primary care for pregnant patients has led to care that is highly interventionist, resource intensive and provided largely in hospital.

Despite the expansion of midwifery, patients still experience barriers to accessing midwifery care. Barriers are primarily twofold and occur at the hospital level. First, 52% of midwives face scope of practice **restrictions**. For patients, this means they lose their midwife as their primary care provider even though the care needed is *within* the midwife's scope of practice—increasing risk to

patient safety¹⁶ and denying patients continuity of care provider. For the health system, this means that two providers are paid for providing the same service, which means the Ministry pays double what it should for this service. Second, at least 24% of midwifery practices cannot meet demand for care because hospitals are restricting the number of midwifery privileges and births.¹⁷ A midwife cannot provide care to a patient without privileges, as an integral part of midwifery care is being able to move seamlessly between the patient's home, the community and the hospital – providing care where it's most appropriate.

Midwives cannot provide seamless care to patients if access to hospitals that provide labour and delivery services is compromised. However, **centralization** is a troubling trend that drives birth away from community.¹⁸ Evidence demonstrates that requiring patients to travel away from their community for maternity care leads to undesirable results, namely: poorer outcomes; the atrophy of other aspects of health-care; withdrawal of family physicians from the community; loss of skill sets in remaining health care providers; and exodus of businesses and residents from the community.¹⁹

GAPS IN MIDWIFERY INTEGRATION

52% of midwives face scope of practice restrictions.

24% of midwifery practices are prevented by hospitals from expanding to meet demand for care.¹⁶

Medically unnecessary transfers of care increase risk to patient safety.¹⁷



"I felt like I wasn't alone. I felt like I had all these women there encouraging me and supporting me...It wasn't just the midwives in the room with me; it felt like it was all of my ancestors there. It was just that powerful. It just gave me that strength that I think I needed."

Sara Luey (client of Aboriginal midwives at Seventh Generation Midwives Toronto)

[Watch Sara's full story](#) 

ALARMING GAPS IN ABORIGINAL MATERNAL AND NEWBORN CARE

Processes of colonization over the last 100 years, including residential schools, which profoundly disrupted entire systems such as health-care delivery, have eroded midwifery in most Aboriginal communities. Aboriginal people face alarming disparities in health outcomes^{20,21} and the most vulnerable women and children face the greatest disparity.²²

Aboriginal populations have a younger demographic and higher birth rate. Between 1996 and 2006, the overall Aboriginal population grew by 45%, compared with 8% for the non-Aboriginal population in Canada,²³ placing additional emphasis on the need to ensure quality care in Aboriginal communities.

Conflicts within the health-care system can arise due to differing views regarding health held by Aboriginal peoples and Western medical systems.²⁴ These conflicts can create barriers to care and result in experiences of paternalism and racism.²⁵ In one study, the fear of experiencing racism meant women were less likely to seek out care in the first place.³⁰

Since the 1960s, modern obstetrical practices replaced midwifery in Aboriginal communities, and since most communities didn't have obstetrical facilities or staff, women had to leave their communities to give birth. The history of routine evacuation, its negative consequences, and the relationship between stress and negative birth outcomes has been well documented.²⁷ Some point to the practice





Six Nations of the Grand River territory midwifery client Carly Vyse (second from left) holds her one-month-old son Isaac while her mother-in-law Debra Vyse (left) and two-year old daughter Madalyn (right) look on.

of routine evacuation from a home community for birth as the “colonization of birth”²⁸ and the “residential schools of medicine”²⁹ because it disrupts and undermines the individual health of the woman and newborn and that of the entire community. The residential school system, and the process of removing children from their families and communities, has been widely acknowledged as a “profound failure,”³⁰ and as “cultural genocide.”³¹ Christine Roy, a midwife in Attawapiskat similarly describes routine evacuation for birth as a profound failure and as eroding culture.

The substitution of community-based midwifery with routine evacuation has created a system whereby women must choose between their culture and their safety, making women face an impossible choice.³² The way out of this impossible choice is to offer Aboriginal midwifery care in isolated communities.

Routine evacuation is extremely costly. A midwife assisted-birth, which avoids evacuation is estimated to save \$12,000.³³ Having one of life’s most affirming events removed from a community and taken out to a faraway place leads to increased depression, loss of ceremony and culture.³⁴ The cost then is not just financial,

but much more profound, in that it continues processes of colonization.

Midwives are the key to reversing alarming maternal and newborn health outcomes for Aboriginal peoples. Aboriginal midwives are primary care providers, keepers of ceremonies, leaders and mentors. They restore birth to communities, dignity to mothers and families and allow joy to flow from the sacred event of welcoming a new life.

ALARMING MATERNAL AND NEWBORN HEALTH DISPARITIES IN ABORIGINAL COMMUNITIES

Infant mortality is at least twice as high: 1.7 to 4 times higher.³⁵

Children are more likely to die in the first year of life.³⁶

Higher rates of low and high birth weight babies, preterm birth, gestational diabetes, and C-sections.³⁷

Aboriginal midwifery is key to restoring the health and well being of individuals and communities.

Leveraging Midwives to Strengthen Maternal and Newborn Primary Care in Ontario

The MOHLTC has proposed to reduce gaps and strengthen patient-centred care by expanding the role of the LHINs. Below, our input seeks to stress the critical importance of addressing gaps in maternal and newborn care as part of primary care transformation. In particular the LHINs can play a leadership role in reorienting maternal and newborn care to primary care. Driven by a commitment to high-quality and well-integrated midwifery, we hope government will direct LHINs to reward hospitals that are leaders in integration and to incentivize hospitals who are not adhering to best practices to do so.



However, before providing recommendations for the LHINs, we must stress the need for a provincial maternal and newborn care strategy. The province spends approximately \$1 billion per year a year on maternity care services; however, there are no province-wide policies or strategies in place for low-risk maternal and newborn care.³⁸

We understand PCMCH has begun this task and we look forward to seeing this work come to fruition.

Furthermore, given that Indigenous communities have been stripped of midwifery through processes of colonization, we also stress the need for a specific Aboriginal midwifery strategy that is dedicated to the renewal of midwifery in Aboriginal communities in each of the LHIN regions.

RECOMMENDATIONS

1. More effective integration of services and greater equity

Integration cannot simply be seen as shared care between providers, but rather must ensure that communication and transfers of care are effective, and that movement from home to community to hospital is seamless. It's about ensuring patients see the number of providers they need to receive the best care, and no more. Barriers to integration, such as caps on the number of midwives practicing in hospitals or on the number of midwifery-assisted births, lack of specialist funding for physicians, and hospital funding formulas that penalize midwifery-assisted births by fiscally favouring high-risk care, must be addressed to make maternal and newborn care patient-centred.

LHINs can:

- **Ensure health human resource planning for maternal and newborn care at a local level** includes an understanding of midwifery and its potential to address gaps in care, keep birth close to home and provide quality and value. Over the long term, this would signal a shift in who provides maternal and newborn care in Ontario. For example, the role of obstetricians would shift from being responsible for low-risk births to being valued for their role in caring for high-risk pregnancies and acting as consultants to primary care providers such as midwives and family physicians.



[Click here](#) for more information on the care midwives provide in hospital.

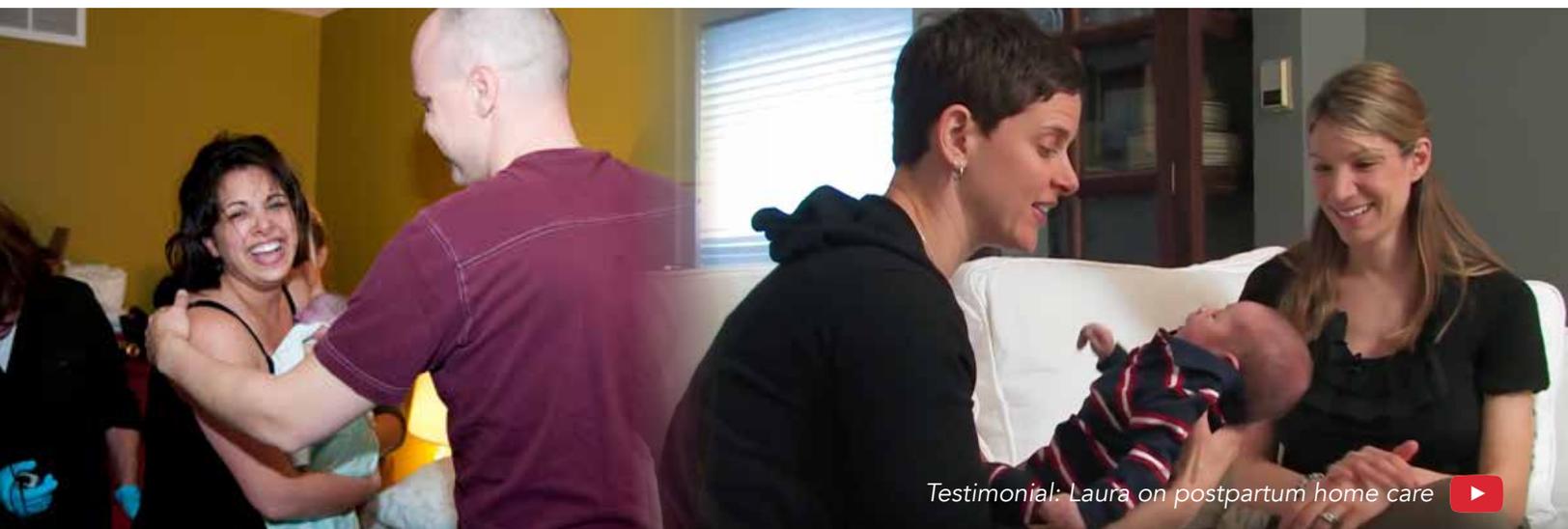
- **Address barriers to midwifery integration at the hospital level:**
 - » **Require hospitals to monitor and evaluate restrictions on midwives and the percentage of midwifery-assisted births.** This would assist LHINs in identifying which hospitals in their region are capping the number of midwives and/or the number of midwifery births and thereby limiting patient access to midwifery. In addition, tracking unaccommodated requests for midwifery care and understanding these unmet needs in the context of restrictions will also assist LHINs in making improvements to access and to reorienting maternal and newborn health towards primary care.
 - » **Ensure providers are not restricted by hospitals from providing care to their full scope of practice.** This would eliminate unnecessary transfers of care for patients, decrease unnecessary risk to patient safety, save the unnecessary expense to the system of paying both an obstetrician and a midwife for work that is within a midwife's scope of practice, and ensure patients receive continuity of care, a defining principle of midwifery care and of quality care.^{39,40,41}
 - » **Develop a standardized credentialing policy for hospitals** within LHIN regions.⁴² Standardized policies within LHIN regions can assist integration efforts by providing midwives who are applying for privileges with a process and ensuring consistency across hospitals within LHIN regions.

2. Timely access to primary care and seamless links between primary care and other services

LHINs can:

- **Improve access to primary care** by increasing access to maternal and newborn primary care providers, **specifically midwives**. Currently one out of four patients cannot access midwifery and one of the significant barriers to expanding midwifery services is hospital restrictions, as outlined on the previous page.
- **Ensure the midwifery sector is included in e-health strategy and implementation** and that midwifery clients have EMRs that allow them to move seamlessly between providers and care settings. EMRs are an important part of ensuring effective integration and supporting the reorientation of maternal and newborn health into the community setting so that patients can access care where needed and where most appropriate and ensure that their medical information is with them as they move between settings.

- **Ensure that proper equipment is available to providers working in the community**, such as portable bilirubinometers, to promote keeping care in the community.
- **Support midwives working in new and innovative ways**, like in midwifery-led hospital units and Community Health Centres. Also support those with extended scope to provide community-responsive care that may include care outside of pregnancy, birth and six weeks postpartum for example.



Testimonial: Laura on postpartum home care

3. More consistent and accessible home and community care

“One of the most amazing parts of having a midwife is the home care. You get to have her come to your home for the birth and when you’re postpartum and healing, you don’t have to go anywhere. Your midwife can see you breastfeeding when you’re in your own home and not in a stressful, difficult environment. That is so helpful.”

Miquela Skinner, (midwifery client who had a home birth with midwives in Ottawa)

LHINs can:

- **Promote out-of-hospital birth and postpartum care and work towards making out-of-hospital birth the normative option.** Promoting community birth, whether at home or at a birth centre, is safe and reduces strain on hospitals. Evidence-based guidelines from the U.K. recommend offering all low-risk women midwifery-led care and out of hospital settings for birth.⁴³ Ontario data shows lower rates of C-sections for women planning home births with midwives.⁴⁴
- **Keep birth close to home. Monitor the practice of maternity unit closures and ensure that birth is geographically accessible to all Ontarians.** The centralization of maternity care in the province, by its very nature, requires travel for an increased number of families

for birth and is too often driven by short-sighted cost considerations rather than best practices in patient-centred care.

- **Participate in strategies to end routine evacuations from the far North, a practice which disproportionately affects Aboriginal communities.** Removing women from their communities and support networks weeks before they give birth can be emotionally isolating and traumatic, and has been referred to as the “residential schools of medicine.”⁴⁵ This practice interrupts cultural and familial practice. LHINs must work to end routine evacuation by actively supporting the renewal of Aboriginal midwifery.

Testimonial: Ted and Joanne on their home birth



CONCLUSION

Pregnancy and birth are healthy life events best managed by primary care providers who are well integrated into the health-care system, are supported by specialists and are able to deliver care at home and in the community.

Our current maternal and newborn health system, however, is neither rooted in primary care nor is it delivered in the community. In fact, quite the opposite is true. Specialist obstetricians attend 84.7% of births. High rates of interventions mean that, for example, one out of four patients deliver by C-section. Despite evidence that demonstrates community-based care (including home birth) is safe and keeps birth normal, too few Ontarians have access to midwifery-led care and birth centres.

That's why we're urging government to leverage midwives to reorient maternal and newborn health away from high-intervention and hospital-based care toward primary and community-based care. In order for this change-of-course to take place, barriers to midwifery integration, specifically those at the hospital level that restrict scope of practice and the number of midwives able to provide care in a given community, must be addressed.

In Aboriginal communities in particular, where colonialism has eroded Aboriginal midwifery, maternal and newborn care is not only oriented

towards high-intervention and hospitals, but also strips individuals and families of culturally-appropriate and responsive care. For Aboriginal peoples in the far North, the routine evacuation of healthy patients to give birth in faraway cities is especially disastrous and damaging, not only for individuals but also for entire families and communities. A provincial strategy to reorient maternal and newborn health for Aboriginal peoples, which champions the renewal and restoration of midwifery, is long overdue.

Midwives are eager to be part of health transformation and we look forward to working with the MOHLTC, LHINs and the Provincial Council for Maternal and Child Health to fashion a system of maternal and newborn care that extends the benefits of midwifery, with its proven efficacy, outcomes and value to all Ontarians.

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