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## Regulating and Funding Midwifery in Nova Scotia

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## Abstract

Midwives have been working in Nova Scotia for many years, and midwifery became a government funded and regulated health profession in the province in 2009. Despite the will among many decision-makers in the province to regulate the profession since the mid 1980s, several elections and lack of a management model slowed the program's development. Implicit goals of having midwifery services included improving the quality of maternal care and health outcomes, keeping up with other provinces, responding to public demand, and saving costs. Strong and persistent bureaucratic and public advocacy work, inter-party collaboration, and research demonstrating positive and safe maternal and newborn health outcomes under midwifery care all had a role in the decision-making process. The implementation responsibility was delegated to three health districts in the province, each being responsible for designing a program to integrate midwives into maternal health care teams. The program has thus far been evaluated in an ad hoc manner with external teams performing comprehensive assessments, though the need for a cost-benefit analysis as well as more systematic assessments has been identified. Though many opportunities exist with midwifery in the province, including a continued high demand for the service, and research demonstrating positive outcomes for mothers and babies, significant challenges and threats remain to be addressed to ensure long-term sustainability of the program.

*Il y a eu des sage-femmes en Nouvelle-Écosse depuis longtemps, et l'occupation de sage-femme est devenue une profession réglementée et financée par le gouvernement de la province en 2009. Il y avait un intérêt gouvernemental à réguler les sage-femmes depuis les années 1980, mais des élections fréquentes et l'absence d'un modèle d'administration pour le programme ont entravé sa réalisation. Parmi les objectifs implicites à la reconnaissance des services des sage-femmes se trouvaient l'amélioration de la qualité des soins maternels et des résultats de santé maternelle, ainsi que la volonté de ne pas être distancé par les autres provinces, de répondre à la demande du public, et de diminuer les coûts. Le processus de décision a aussi été facilité par une pression constante et forte de la part de la bureaucratie et du public, la collaboration entre les partis politiques, et les résultats de la recherche académique montrant que les soins de sage-femmes produisaient des conditions de sécurité pour les mères et de bons résultats de santé pour les nouveau-nés. La responsabilité d'implémentation du programme a été déléguée à trois juridictions de santé, chacune ayant la responsabilité d'intégrer les sage-femmes dans leurs équipes de soins maternels. Le programme n'a pour l'instant été évalué que de manière parcellaire et ad-hoc par des équipes externes menant des études complètes, mais le besoin d'analyses plus systématiques et d'analyses en coût-bénéfices a été identifié. Bien qu'il existe de nombreuses raisons pour le succès d'un programme de sage-femmes en Nouvelle-Écosse, notamment une forte demande de la part des familles et les résultats de recherche montrant des résultats positifs*

*pour les mères et les bébés, des défis considérables doivent encore être surmontés afin de garantir la pérennité de ce programme.*

### Key Messages

- There has been commitment across multiple stakeholders for the implementation of midwifery services in Nova Scotia.
- Provincial elections and changes in legislature slowed the progress of the establishment of a midwifery program in Nova Scotia.
- Current evaluations of midwifery programs in Nova Scotia are limited due to barriers related to implementation of these services.

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- *Plusieurs parties prenantes se sont engagées à mettre en place des services de sage-femmes en Nouvelle-Écosse.*
  - *Les élections provinciales et les changements de législatures ont ralenti les progrès de la mise en place d'un programme de services de sage-femmes en Nouvelle-Écosse.*
  - *Les évaluations actuelles des programmes de services de sage-femmes en Nouvelle-Écosse sont de portée limitée en raison des obstacles à la mise en place de ces services.*

## 1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

On 23 November 2006, the Nova Scotia (NS) Midwifery Act 2006,c.18,s.1 was declared in the NS House of Assembly. NS thus became the seventh province/territory in Canada to regulate midwifery. The Midwifery Regulatory Council of Nova Scotia (MRCNS) was created, which later wrote specific regulations governing the services, approved in March 2009 (N.S. Reg. 58/2009).

Midwifery services include prenatal assessments and checkups, monitoring during labour and delivery, and postnatal care for women and newborns. Midwifery services can include home births, depending on the decision of the mother and the availability of personnel.

Midwives have been working in Canada and Nova Scotia (NS) for many years, however the profession has been privately funded, managed, and delivered. A variety of factors including strong public support and advocacy for the program, studies showing better health and wellness outcomes for mothers and babies under midwifery care, and demonstrated cost savings from other provinces led to the drive to regulate and publicly fund midwifery in the province. However, significant political changes and the need to craft a midwifery model of care that fit in the Nova Scotian context slowed the progress of the legislation.

Seven midwives in total were licensed and hired in the province in three Health Districts (Kaufman et al. 2011). Different evaluations of the midwifery programs in the province have been done, mainly in an ad hoc manner, and have suggested that the program is not operating at its most effective level.

## 2 HISTORY AND CONTEXT

- 1985: ➤The death of an Ontario baby under the care of a midwife leads to pressure to legislate the profession (Born 2004).
- 1994: ➤Ontario becomes the first Canadian province to regulate and fund midwifery.
- 1997: ➤[Liberal] government receives feasibility assessment and recommendations for midwifery services (Potential for Midwifery in Nova Scotia, A Review by the Reproductive Care Program of Nova Scotia) (Daniels 1997).
- 1999: ➤Provincial election; ➤[Progressive conservative] government receives feasibility assessment and recommendations for midwifery services (Recommendations for the Regulation and Implementation of Midwifery in Nova Scotia) (Davis-Murdoch and McMillan 1999).
- 2003: ➤[Progressive conservative] government receives recommendations for midwifery services (Primary Health Care Renewal: Action for Healthier Nova Scotians) (Rippey 2003); ➤Provincial election.
- 2005: ➤[Progressive conservative] government receives recommendations for midwifery services from the Primary Maternity Care Working Group.

- 2006: ➤Provincial election; ➤Midwifery Act approved in NS legislature.
- 2009: ➤MRCNS regulations approved in NS legislature; ➤First licensed and funded midwives in NS begin practice.

### **3 GOALS OF THE REFORM**

#### **3.1 Stated**

Regulate and fund midwifery services in NS.

#### **3.2 Implicit**

There were many implicit goals for the reform (NS Legislature 2006; additional sources noted):

- Demedicalize childbirth: treat pregnancy and birth as a natural process, not a medical emergency
- Improve birth outcomes: fewer medical interventions and prevention of pre-term births (Sandall et al. 2013)
- Respond to the decreasing number of physicians performing obstetric services in the province (Martin 2005)
- Reduce costs to the health care system (Saulnier 2005)
- Respond to demand and advocacy for midwifery services from the NS population
- Provide more equitable access to midwifery services. Midwifery was previously a private market so only those who could afford services could receive them. With the regulation, access to services would become first-come, first-served for low risk pregnancies and births.
- Keep up with the six other Canadian provinces and territories and other industrialized nations which already regulate and fund midwifery
- Provide more continuous maternity care by having one primary care provider or one core team

### **4 FACTORS THAT INFLUENCED HOW AND WHY**

#### **4.1 The issue came onto the government's agenda**

Midwives have been practicing in Canada and across the world since women have been having children. However, many of these services were unregulated and unmonitored by governments. The status of midwifery in Canada was brought to the public eye after the death of an Ontario baby in 1985 under the care of an unlicensed midwife (Born 2004). NS had explored the establishment of midwifery services in the late 1990s (as other provinces established programs), but provincial elections (in 1998, 1999, 2003, and 2006) and changes

in legislature likely slowed this process as midwifery moved on and off the governmental agenda as various working groups produced feasibility assessments.

The Minister of Health in 2006 also noted that the self-regulating and licensing model for midwifery used in other provinces presented challenges in NS due to low population and thus very low number of eligible midwives to be part of the regulatory board (NS Legislature 2006).

## 4.2 The issue came onto the government's decision agenda

By the time the Midwifery Act was presented in the legislature, six provinces and territories had already regulated, and for the most part funded, midwifery programs. There was likely some peer pressure on NS to lead the Atlantic provinces in implementing a program.

Following the recommendations for the establishment of midwifery as part of the 2003 report on primary health care renewal, the DHW<sup>1</sup> Primary Maternity Care Working Group was formed. This group later played a role in drafting legislation that was presented to the Minister of Health in 2005 (Martin 2005). The self-regulating challenge was solved by having a board (the MRCNS) composed of midwives and other maternal health experts (NS Legislature 2006).

In addition, many non-profit and research organizations, led by the Midwifery Coalition of Nova Scotia (MCNS), took strong advocacy roles for midwifery, keeping the topic visible to politicians and the media (*Ibid.*).

## 4.3 The final decision was made or not made

Much research was also happening around the topic of midwifery. Sandall et al. (2013) conducted a meta-analysis of randomized control trials for midwifery (16,242 women in total) done between 1989 and 2012 and concluded that maternal care with hospital births with midwives as the primary practitioners led to significantly less regional analgesia, less episiotomy, less instrumental birth, significantly lower likelihood of pre-term births and fetal loss before 24 weeks gestation, and significantly more spontaneous vaginal birth. The study found no significant difference in cesarean section occurrence or in fetal survival. Sandall and colleagues (2013) also indicated that qualitative research suggests cost savings and higher levels of maternal satisfaction with midwifery care than with other types of medical personnel. This fits in well with the broader literature known to policymakers at the time, including work done in Ontario, that suggested that having midwives as the primary practitioners for pre-, intra- and post-partum care led to higher maternal satisfaction, less medical intervention in birth, higher breastfeeding success, shorter hospital stays, and was

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<sup>1</sup>The Department of Health and Wellness was officially called the Department of Health prior to January 2011. For consistency, "DHW" will be used throughout the paper, including when it refers to its administrative equivalent in dates before 2011.

more cost effective than physician delivered care (O'Brien et al. 2011; Saulnier 2005). Midwifery was therefore seen as a desirable option to policymakers at the time.

In the summer of 2006, an election was held, re-electing a minority Progressive Conservative caucus under new leadership but with a stronger presence in legislature from the New Democratic Party (NDP), the opposition. The introduction of the Midwifery Act by the Minister of Health was perhaps an attempt to increase political popularity of the new legislature, setting the tone for a less partisan approach to decision-making as many members of the NDP advocated on behalf of the bill (NS Legislature 2006).

## 5 HOW THE REFORM WAS ACHIEVED (OR FAILED)

### 5.1 Policy instruments

The creation of the *Midwifery Act: An Act Respecting Midwifery* Bill No. 107 (2006) mandated the later creation of the *Regulations Respecting Midwifery* (N.S. Reg. 58/2009). These regulations outlined the licensing, competencies, remuneration, pharmaceutical privileges, and disciplinary procedures for midwives.

### 5.2 Implementation plan

Funding was distributed from the DHW to three 'model sites' the South Shore District Health Authority, the Guysborough Antigonish Strait Health Authority, and the IWK Hospital (of the Capital District Health Authority, Halifax). Each site was given the discretion to create a collaborative maternal care model involving the hiring and insuring of midwives. At all sites, the midwives worked in existing hospitals or clinics but did home visits as possible given time and scheduling constraints of the midwives.

Midwives were to be the primary practitioners for certain clients for prenatal (from the start of pregnancy), delivery, and post-natal care (up to 6 weeks post-partum), and complicated pregnancies or births were to be managed with or passed over to obstetricians and other members of the medical team. The possibility for home births was very limited due to the need for two trained birth attendants, requiring two midwives be on call at the time of birth (MCNS 2010; Kaufman et al. 2011). Consequently, the possibility of home births has varied over time and across regions. Training programs and information sessions were done at each of the three model sites to facilitate integration of the midwives onto existing maternal care teams.

Enough funding was distributed to hire seven midwives in total for the province as salaried employees for the local health authority/hospital. Practicing midwives who were not hired were given the option to continue practicing privately, but under the new regulations that required registration fees and insurance. These costs were restrictive so no non-government funded midwives continued to practice in the province (MCNS 2010). This

also limited geographic access to services, especially for women living outside of these three districts (*Ibid.*).

The MRCNS was established; its responsibilities included the regulation, licensing, monitoring, and evaluation of the program. The Midwifery Evolution in Nova Scotia (MEINS) committee was also created which oversaw the overall implementation and initial evaluations in the province. The stakeholders of this committee included representatives from the district health authorities, the DHW, and medical practitioners.

### 5.3 Communication plan

Despite regulation and funding on the part of the provincial government, very little coordinated messaging or communication about midwifery was done by the DHW and was mainly delegated to the model sites. Each site attempted to make prospective midwifery clients aware of the program in the district through local media and on their websites, though formal communication strategies are unknown.

## 6 EVALUATION

### 6.1 Process of evaluation, conducted/planned

One of the MRCNS's mandates was to have a quality-assurance program, though the details were not established in the law. The MRCNS indicates that they are in the process of establishing systematic evaluation procedures (2012). Several *ad hoc* evaluations were undertaken in the meantime.

The focus of these initial evaluations has been on workplace integration and client satisfaction. Data on birth outcomes is collected and made available through the Nova Scotia Atlee Perinatal Database, though a formal analysis of outcomes with respect to midwifery services has not been done. A cost-benefit analysis and peer-case reviews have been identified as necessary components of program evaluation, but are being delayed until after the implementation period.

An initial implementation report and a client report were commissioned by MEINS, which were done by a private consulting group, and the MCNS, respectively. Both reports were released in 2010. An additional evaluative report was commissioned the year after by the DHW to make recommendations for strategic program action after worrying results from the 2010 evaluations were disclosed and three practicing Halifax midwives resigned, mainly due to the inability to provide optimal midwifery services and personnel conflict around perinatal care decisions (Kaufman et al. 2011).

### 6.2 Impact evaluation

Both Implementation of Midwifery in Nova Scotia (Research Power, Inc. 2010) and Midwifery in Nova Scotia: Report of the External Assessment Team (Kaufman et al. 2011)



noted some major challenges with the implementation, which varied across the three sites. These included administrative difficulties (lack of resources for paperwork and confusion between clinical and administrative hierarchy), difference of philosophy, interpersonal conflicts, on-call time, responsibility and remuneration of physicians, and access for vulnerable persons. They also noted the inability for the full range of midwifery services (namely, home births) to be performed due to lack of personnel (Kaufman et al. 2011; Research Power, Inc. 2010). Indeed, New Brunswick’s midwifery program de-funded in 2013, citing the need for multiple attendants at home births as a significant financial barrier (CBC 2013).

Additionally, Kaufman et al. made several recommendations regarding the program: certifying birth attendants to allow more home births, changing administration to allow more autonomy in midwifery practices, changing remuneration schemes for physicians performing obstetrics to allow for more unconstrained consultation with midwives, increasing promotion and access of midwifery services to vulnerable populations, and providing training opportunities for midwives in the Atlantic Provinces (2011).

Uncomfortable Positions: Consumer Comments on Midwifery Implementation in Nova Scotia (MCNS 2010) highlighted that most clients were satisfied with their midwifery service under the new program, though a few cited that the interprofessional tension was sometimes stressful. Many expressed frustration at not being able to have a home birth due to limited personnel, and many non-clients were discouraged that they were unable to access the services at all (Research Power, Inc. 2010; MCNS 2010).

Since these evaluations, two midwives have been hired at the IWK site and a Midwifery Practice Specialist was hired in spring 2013 (MCNS 2013).

## 7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1 presents a summary analysis of the strengths, weaknesses, opportunities and threats associated with the implementation of a midwifery program in Nova Scotia.

Table 1: SWOT Analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>• Many maternal and child health outcomes are shown to be better with midwives. For example, care with midwives has a lower likelihood of regional analgesia, instrumental birth, pre-term birth, and fetal loss before 24 weeks gestation (Sandall et al. 2013).</li> </ul>	<ul style="list-style-type: none"> <li>• Shortages in midwifery workforce prevents optimal delivery of services (e.g., home births).</li> <li>• Physicians are losing income under the current remuneration scheme as they are not being paid for consultation with midwives.</li> </ul>

STRENGTHS (cont'd)	WEAKNESSES (cont'd)
<ul style="list-style-type: none"> <li>● Client satisfaction with midwifery care is high (MCNS 2010; O'Brien 2011; Saulnier 2005).</li> <li>● Midwifery can be more cost-effective than physician attended births (Sandall et al. 2013; Saulnier 2005).</li> <li>● More specialized health care professionals trained in maternity care.</li> <li>● Government may gain political support from women.</li> </ul>	<ul style="list-style-type: none"> <li>● Tension between physicians and midwives</li> </ul>
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> <li>● Demand for midwifery is high in NS.</li> <li>● Continued success of midwifery programs in other provinces could have rippling effects.</li> <li>● Labour mobility: potential for collaboration with midwives in other provinces</li> <li>● Could be a model for an interdisciplinary maternal health service delivery</li> </ul>	<ul style="list-style-type: none"> <li>● Lack of awareness and understanding of midwives' scope of practice</li> <li>● Difficulties with implementation of midwifery care may lead to unsatisfactory experience and decrease support for the program.</li> <li>● Funding for establishment of midwifery program cancelled in New Brunswick. This could have rippling political effects.</li> </ul>

## 8 CONCLUSION

Frequent changes in legislature due to elections delayed the process of establishing a midwifery program in NS for many years, despite persistent evidence from the academic literature and from other provinces suggesting midwifery is both a medically responsible and cost-effective option for peri- and post-natal care for women and newborns.

Continued challenges with the operation of the midwifery program in the province—specifically related to difficulty in integrating midwives into existing maternal teams and to the shortage of personnel to operate at its most effective capacity—have delayed program evaluations and broader political and social success of the NS midwifery program.

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## 10 FOR MORE DETAIL

### 10.1 General information

Atlantic Centre for Excellence in Women's Health: Midwifery <http://www.dal.ca/diff/Atlantic-Centre-of-Excellence-for-Womens-Health/projects-and-publications/health-status-and-services/midwifery.html>

Midwifery Coalition of Nova Scotia <http://mcns.chebucto.org/>

Midwifery Regulatory Council of Nova Scotia <http://www.mrcns.ca/>

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