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Introducing Midwifery-led Birth Centres to Ontario

Cristina A. Mattison, *McMaster University, Hamilton, Ontario, Canada*

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A Provincial/Territorial Health Reform Analysis

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Abstract

In Ontario, maternal health systems are changing, with an increasing variety of childbirth options being offered to low-risk pregnant women. Midwifery became a regulated profession in the province in 1994: providing primary care throughout pregnancy, labour and for up to six weeks postpartum. Currently there are three midwifery-led birth centres operating in Ontario, two of which opened in early 2014. The Ministry of Health and Long-Term Care (MoHLTC) has launched these new birth centres in order to offer women more choice in health care provider and birth setting. This shift is representative of the MoHLTC's push to move services out of hospitals and into community-based settings. While the birth centre initiative is in its early stages and a formal program evaluation is needed, it has the potential, if scaled up, to decrease the need for hospital beds as well as reduce health care costs through more appropriate care for low-risk pregnancies, leading to fewer interventions.

L'accroissement de l'éventail des choix pour l'accouchement offerts aux grossesses à bas risque est en train de faire évoluer les systèmes de santé maternelle en Ontario. La profession de sage-femme est régulée en Ontario depuis 1994. Les sages-femmes fournissent les soins primaires pendant la grossesse, l'accouchement et dans les six semaines post-partum. Il existe aujourd'hui trois centres de naissance dirigés par des sages-femmes en Ontario, dont deux ont ouvert au début de 2014. Le Ministère de la santé et des soins de longue durée (MSSLD) a créé ces centres de naissance afin d'offrir aux femmes un plus grand choix de types d'accouchement (personnels et lieux). Ce changement est représentatif d'un virage ambulatoire du MSSLD. Bien que l'initiative des centres de naissance n'en soit qu'à ses débuts et qu'une évaluation officielle du programme soit encore à venir, elle est susceptible, si généralisée à l'ensemble de la population, de diminuer la demande pesant sur les lits d'hôpitaux et de réduire les coûts des soins en fournissant des soins appropriés aux grossesses à bas risque nécessistant moins d'interventions.

Key Messages

- While midwives have been a regulated health profession in Ontario since 1994, midwifery-led birth centres are a new initiative by the Ministry of Health and Long-Term Care.
- Two new birth centres in Ontario opened in early 2014 and are indicative of the Ministry of Health and Long-Term Care's departure from hospital services to community-based care and its increasing recognition of the role of alternative health care providers in labour and delivery.

Messages-clés

- *Bien que la profession de sage-femme ait été réglementée en Ontario dès 1994, les centres de naissance dirigés par des sage-femmes sont une nouvelle initiative du Ministère de la santé et des soins de longue durée.*
- *Deux nouveaux centres de naissance ont ouverts au début de 2014 et sont significatifs du virage ambulatoire pris par le Ministère de la santé et des soins de longue durée ainsi que de la reconnaissance croissante du rôle des fournisseurs alternatifs de soins de santé dans le travail et l'accouchement.*

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1 BRIEF DESCRIPTION OF THE HEALTH CARE REFORM

Midwifery became a regulated health profession in Ontario in 1994 and the College of Midwives of Ontario (CMO) is the provincial regulatory body for the profession, which operates in accordance with the *Midwifery Act* (O. Reg. 168/11) and *Regulated Health Profession Act* (S.O. 1991, Chapter 18) (Bourgeault 2006; College of Midwives of Ontario 2014a). Midwives' scope of practice includes providing primary care to low-risk pregnant women throughout pregnancy and labour and for up to six weeks postpartum. Funding for midwifery services in Ontario is provided by the Ministry of Health and Long-Term Care (MoHLTC) and as of March 2014 there are over 700 registered midwives in the province (College of Midwives of Ontario 2014b).

Until recently, women who chose midwifery care had the option of birthing at home or in a hospital setting. As of 2014 there is a third option being offered. The MoHLTC has launched two community-based birth centres; one is located in Ottawa (Ottawa Birth and Wellness Centre) and the other in Toronto (Toronto Birth Centre). Former Minister of Health and Long-Term Care Deb Matthews stated that birth centres will offer women more choice by moving routine procedures out of hospitals while providing high quality care (MoHLTC 2014). This initiative was part of the Liberal government's Action Plan for Health Care to provide timely, high quality care in the community (MoHLTC 2012a).

2 HISTORY AND CONTEXT

Before the 20th century midwives in Canada operated in an informal capacity as birth attendants and were the predominant provider at birth. They were often local women with informal training who played multiple roles, not only attending births but also helping with housework and childcare (Bourgeault 2000). By the turn of the last century, midwives were pushed to the periphery of the maternal health system in favour of a growing medical profession that preferred attending births in a hospital setting. It was not until the late 1960s and early 1970s that there was a resurgence of midwifery; this is attributed to British influence and their valuing of midwives, as well as a stream of ideas and advocates coming from the United States (Bourgeault, Benoit & Davis-Floyd 2004). Over time, the social movement grew and the "new" midwifery practice was born, centring on midwives providing support, information and advice to clients in a way that prioritizes the needs and wishes of the pregnant woman (Bourgeault 2000).

In Ontario, the first important step towards the regulation of midwives was the formation of the Ontario Association of Midwives in 1981 (Bourgeault 2000). In 1983 the Health Professions Legislation Review was established to review health professions in Ontario and the Midwifery Coalition and the Midwifery Task Force of Ontario developed a case to integrate midwifery into the health system (Bourgeault 2000). By the end of 1993,

the *Midwifery Act* was enacted and the CMO was created. The following year (1994), formal midwifery education programs (at McMaster, Ryerson and Laurentian universities) were created and midwives secured hospital privileges with the ability to practice in both home and hospital settings (Bourgeault 2006). Ontario was the first province in Canada to regulate midwifery and some provinces and territories have yet to regulate the profession (Canadian Association of Midwives 2013).

The Ontario midwifery model of care focuses on community-based practices where prenatal care is provided in the community and clients have a choice of birth setting (home or hospital), while early postpartum care is provided in the client's home (College of Midwives of Ontario 2014c). Demand for midwifery services is increasing in Ontario and many practices have waitlists, with up to 40% of women seeking this type of care being unable to access it (Association of Ontario Midwives 2013). The MoHLTC reported that 8,000 Ontario babies were born with the assistance of midwives in 2003, with that number rising to 22,000 in 2013 (MoHLTC 2014). The new birth centres are regulated by the CMO under the Independent Health Facilities Act (MoHLTC 2013).[1]

While there is no Ontario-specific research evidence available on birth centres, the majority of midwives in Québec practice within birth centres (Canadian Association of Midwives 2013). Québec is the only province to formally pilot midwifery practice before legislation, which included eight pilot birth centres (Collin *et al.* 1999). Both quantitative and qualitative data were collected to evaluate the pilot. Results suggest that compared to physician services, midwifery clients were more satisfied and empowered by the care they received, midwifery was associated with greater continuity of care, and midwifery care was associated with fewer obstetrical interventions (Blais & Joubert 1999; Collin *et al.* 1999; De Koninck *et al.* 2001; Fraser *et al.* 1999). An important finding stemming from the research was that of cost-effectiveness. Births in birth centres were found to be less costly ($2,294) to the health care system when compared with those in hospitals ($4,020) (Reinharz *et al.* 1999). Following the positive results for the pilot evaluation, midwifery was regulated in Québec in 1999 (Vadeboncoeur 2004).

Research in the United States on birth centre outcomes suggests they are a safe alternative to a hospital setting and also had lower cesarean rates (4.4%) (Rooks *et al.* 1989). There is one systematic review comparing midwifery-led continuity models of care to other models (countries included in the review are: Australia, Canada, Ireland, New Zealand and the United Kingdom) (Sandall *et al.* 2013). This high-quality systematic review found that midwifery-led continuity models of care were associated with fewer epidurals and episiotomies, and women were less likely to experience pre-term birth and less likely to lose

[1]It is important to note that while the birth centre pilot is a new initiative of the MoHLTC, Ontario has had a birth centre operating since 1996 at the Tsi Non:we Ionnakeratstha Ona:grahsta' Maternal and Child Centre. The centre is staffed by Aboriginal midwives who provide both traditional and contemporary midwifery care to the Six Nations community southwest of Hamilton. Funding for this program is provided by the Government of Ontario's Aboriginal Healing and Wellness Strategy (Six Nations of the Grand River Territory 2006).

their babies before 24 weeks gestation (Sandall *et al.* 2013). Research on Canadian midwifery care in general suggests that midwifery care leads to fewer interventions—including lower rates of induction, cesarean and instrumental deliveries—and women are more likely to experience birth medication-free (O'Brien *et al.* 2011).

3 GOALS OF THE REFORM

A MoHLTC press release states that birth centres will provide women with a safe and comfortable environment in the community, attended to by midwives. It is anticipated that these facilities will provide services for a total of 900 births per year, which will yield a small increase in the availability of hospital beds for high-risk births (MoHLTC 2012b). The overarching goals of this initiative are in keeping with former Premier Dalton McGuinty's Action Plan for Health Care, which heavily supports community-based care (MoHLTC 2012a).

The implicit goals of introducing birth centres and moving the locus of care to the community include cost-effectiveness and appropriate management of low-risk births. Health care cost savings include a significant reduction in average length of stay as well as reduced medical interventions. Task-shifting is another implicit goal, by moving low-risk births to midwifery care, obstetrician/gynaecologist availability is increased for more complex cases.

4 FACTORS THAT INFLUENCED HOW AND WHY

4.1 The issue came onto the government's agenda

Kingdon's (2011) agenda-setting model refers to the process of public policy making and how items move from the governmental agenda to the decision agenda. The governmental agenda is a list of subjects that are receiving interest by those in and around government while the decision agenda is comprised of subjects within the governmental agenda that are up for active decision (Kingdon 2011). The model is made up of three streams: *problems*, *policies* and *politics*. A subject moves onto the decision agenda when there is a coupling of all three streams.

Midwifery-led birth centres appear to have been able to get onto the decision agenda because of a coupling of the three streams facilitated by visible participants and most crucially, a policy entrepreneur. Within the *problems* stream, the government is facing serious budget pressures and, as such, the most significant change in indicator is the rising cost of health care (MoHLTC 2012b). In public communications, the MoHLTC has stated that moving to community-based care, such as birth centres, will provide better value (i.e., safe and cost-effective) when compared to hospital deliveries (MoHLTC 2014). Within the *policies* stream, Ontario's Action Plan for Health Care (2012) emphasizes patient-centred care by moving services out of hospitals into non-profit, community-based clinics.

The purpose of this shift is to offer high quality care that is closer to home while at a cost savings. Several events within the politics stream helped move the issue onto the government agenda. First, the Association of Ontario Midwives was instrumental in its advocacy and support for the program (Association of Ontario Midwives 2013). Second, policy entrepreneurs played an important role: Premier Kathleen Wynne and then Minister of Health and Long-Term Care Deb Matthews offered strong *political* support and served as visible participants. Furthermore, Minister Matthews acted as a policy entrepreneur by having the resources to push the initiative forward and creating a policy window. The policy change also helped to meet women's changing values and increased preference for midwifery services, as evidenced by the increasing patterns for utilization of midwives. It is interesting to note that Minister Matthews' daughter gave birth with midwives and Premier Wynne used midwives (in the Netherlands) for both her births (*CBC News* 2013; *Ottawa Community News* 2013).

4.2 The final decision was made or not made

The decision to introduce birth centres was made by the MoHLTC but, as shown in the preceding section, many factors influenced the initiative. The 3I framework is an analytical framework that focuses on the influence of institutions, interests and ideas on policy choices (Lavis 2013). Institutions and, more specifically, the Ontario health system's structural shift towards community-based care facilitated the implementation of birth centres. Policy legacies such as the *Excellent Care for All Act* (2010), Action Plan for Health Care (2012), and the Patients First: Action Plan for Health Care (2015) instituted under the Liberal government emphasize the patient at the centre of health care and move away from hospital-based care. The Association of Ontario Midwives is a key interest group in advocating for birth centres by harnessing both midwifery professionals and consumer groups. The ideas and values of mass publics have also evolved to place a greater emphasis on women-centred approaches to birth and an egalitarian relationship with care providers (Bourgeault 2000).

5 HOW THE REFORM WAS ACHIEVED

While both birth centres officially opened in early 2014 and are in their infancy, achieving this milestone is of importance as a previous attempt to open a birth centre in Toronto in 1994 failed (Sutton 1996). It is too early to determine whether the goals of the reform have been achieved as preliminary data are not available. Once the birth centres have been running for a sufficient amount of time, a program evaluation is needed. Markers of success for the birth centres include client satisfaction, clinical outcomes, utilization patterns/demand and reduced health care costs when compared to hospital settings. It is interesting to note that initial birth centre communications from MoHLTC referred to the program as a two-year pilot initiative. However, recent communications no longer mention the initiative as a pilot program. Of particular interest, the 2014 Ontario budget discusses

the 10-year plan for the economy and within this section highlights the birth centres as examples of building capacity in the community (Ministry of Finance 2014). This change could be because the pilot was originally introduced under a minority Liberal government, which has since become a majority government with more capacity to enact its health policy vision.

6 EVALUATION

The introduction of midwifery-led birth centres in Ontario is representative of a shift that is taking place in the province, moving low-risk births out of hospitals and into community-based settings. Traditionally, Canadians have valued and placed priority on physician and hospital care as evidenced in the *Canada Health Act* (1985) and in research on Canadians' attitudes toward the health system (Abelson *et al.* 2004). Communications from MoHLTC clearly highlight this departure and it is reflected in the birth centre application guidelines, which state that "the majority of Ontario women are healthy and can expect to have healthy pregnancies, with no medical reason to give birth in hospital" (MoHLTC 2012a, 4). It is too early to determine whether this initiative is a success, and a program evaluation that collects both qualitative and quantitative data on client outcomes and financial viability is needed to appropriately assess the program as well as inform future decisions.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1: SWOT Analysis

Strengths	Weaknesses
• MoHLTC and supporting health care policies are prioritizing community-based care. • Midwifery is well established in Ontario and there is an increasing awareness and demand for these services. • The reform was effectively carried out under a minority Liberal government, indicating broad acceptance for the initiative across political parties.	• A new model of care to the province, which is lacking initial data on the program. • Due to the novelty of the centres, financial viability is unknown. • There is limited research evidence on birth centres and it is restricted to other jurisdictions.

Opportunities	Threats
• Increased potential for cost-effectiveness through appropriate management of low-risk births, leading to fewer medical interventions. • By moving low-risk births into the community, more hospital beds are available for high-risk patients in communities with birth centres. • Possibilities for program expansion into other communities and provision of care to vulnerable populations (rural and remote, Aboriginal peoples, refugee and immigrant, etc.).	• Resistance from other health care providers who are not familiar with the scope of midwifery care or out-of-hospital births. • Obstetricians/gynecologists could oppose losing their low-risk patients.

8 REFERENCES

Abelson J, Mendelsohn MD, Lavis JN, Morgan SG, Forest P-G, Swinton M. 2004. Canadians confront health care reform. *Health Affairs* 23 (3): 186-193. http://dx.doi.org/10.1377/hlthaff.23.3.186

Association of Ontario Midwives. 2013. *Midwifery-led birth centres: an innovative solution to improve care and cut costs.* Toronto: Association of Ontario Midwives.

Blais R, Joubert P. 1999. Evaluation of the midwifery pilot projects in Quebec: an overview. L'Equipe d'Evaluation des Projets-Pilotes Sages-Femmes. *Canadian Journal of Public Health - Revue canadienne de sante publique* 91 (1): I1-4.

Bourgeault IL. 2000. Delivering the 'new' Canadian midwifery: the impact on midwifery of integration into the Ontario health care system. *Sociology of Health & Illness* 22(2): 172-196. http://dx.doi.org/10.1111/1467-9566.00198

Bourgeault IL. 2006. *Push!: the struggle for midwifery in Ontario.* Kingston: McGill-Queen's Press-MQUP.

Bourgeault IL, Benoit C, Davis-Floyd R. 2004. *Reconceiving midwifery.* Kingston: McGill-Queen's Press-MQUP.

Canada Health Act, Revised Statutes of Canada (R.S.C. 1985, c. C-6). Department of Justice Canada. http://laws-lois.justice.gc.ca/eng/acts/C-6/, as of February 2015.

Canadian Association of Midwives. 2013. *Midwifery in Canada - provinces and territories.* http://www.canadianmidwives.org/province/Ontario.html, as of July 2014.

CBC News. 2013. Taking stock with the Premier. *Ontario Today.* http://www.cbc.ca/ontariotoday/2013/11/29/monday-taking-stock-with-the-premier/, as of February 2015.

College of Midwives of Ontario. 2014a. *About the college.* http://www.cmo.on.ca/?page_id=800, as of February 2015.

College of Midwives of Ontario. 2014b. *Annual report 2013-2014.* Toronto: The College of Midwives of Ontario.

College of Midwives of Ontario. 2014c. *The Ontario midwifery model of care.* http://www.cmo.on.ca/?page_id=429, as of February 2015.

Collin J, Blais R, White D, Demers A, Desbiens F. 1999. Integration of midwives into the Quebec health care system. L'Equipe d'Evaluation des Projets-Pilotes Sages-Femmes. *Canadian Journal of Public Health - Revue canadienne de sante publique* 91 (1): I16-20.

De Koninck M, Blais R, Joubert P, Gagnon C. 2001. Comparing women's assessment of midwifery and medical care in Quebec, Canada. *Journal of Midwifery & Women's Health* 46 (2): 60-67. http://dx.doi.org/10.1016/S1526-9523(01)00093-9

Fraser W, Hatem-Asmar M, Krauss I, Maillard F, Bréart G, Blais R. 1999. Comparison of midwifery care to medical care in hospitals in the Quebec pilot projects study: clinical indicators. L'Equipe d'Evaluation des Projets-Pilotes Sages-Femmes. *Canadian Journal of Public Health - Revue canadienne de sante publique* 91 (1): I5-11.

Government of Ontario. 2010. *Excellent Care for All Act.* http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_10e14_e.htm, as of February 2015.

Kingdon JW. 2011. *Agendas, alternatives, and public policies* (Updated 2nd ed). New York: Longman.

Lavis JN. 2013. Studying health-care reforms. *In Paradigm freeze: why it is so hard to reform health care in Canada*, ed. Lazar H, Lavis JN, Forest P-G, Church J. Kingston: McGill-Queen's University Press.

Ministry of Finance. 2014. *2014 Ontario budget: budget papers.* http://www.fin.gov.on.ca/en/budget/ontariobudgets/2014/papers_all.pdf, as of February 2015.

Ministry of Health and Long-Term Care. 2012a. *Ontario's Action Plan for Health Care. Better patient care through better value from our health care dollars.* Queen's Printer for Ontario: Government of Ontario.

Ministry of Health and Long-Term Care. 2012b. *Establishing midwife-led birth centres in Ontario. Application guidelines.* http://www.health.gov.on.ca/en/public/programs/ihf/docs/birthcentres_guidelines.pdf, as of February 2015.

Ministry of Health and Long-Term Care. 2013. *Birth centres.* http://www.health.gov.on.ca/en/public/programs/ihf/birthcentres.aspx, as of February 2015.

Ministry of Health and Long-Term Care. 2014. News Release. *Midwife-led birth centre opens in Toronto. Ontario offering more childbirth options for expecting mothers.* http://news.ontario.ca/mohltc/en/2014/01/midwife-led-birth-centre-opens-in-toronto.html, as of February 2015.

Ministry of Health and Long-Term Care. 2015. *Patients First: Action Plan for Health Care.* http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/, as of February 2015.

O'Brien B, Chalmers B, Fell D, Heaman M, Darling EK, Herbert P. 2011. The experience of pregnancy and birth with midwives: results from the Canadian maternity experiences survey. *Birth* 38 (3): 207-215.

Ottawa Community News. 2013. Ottawa to get one of two Ontario birthing centres. Facility to offer mothers safe, comfortable alternative to giving birth in hospital. http://www.ottawacommunitynews.com, as of February 2015.

Reinharz D, Blais R, Fraser WD, Contandriopoulos AP. 1999. Cost-effectiveness of midwifery services vs. medical services in Quebec. L'Equipe d'Evaluation des Projets-Pilotes Sages-Femmes. *Canadian Journal of Public Health - Revue canadienne de sante publique* 91 (1): I12-15.

Rooks JP, Weatherby NL, Ernst EK, Stapleton S, Rosen D, Rosenfield A. 1989. Outcomes of care in birth centers. The National Birth Center Study. *The New England Journal of Medicine* 321 (26): 1804-11. http://dx.doi.org/10.1056/NEJM198912283212606

Sandall J, Soltani H, Gates SR, Shennan A, Devan, D. 2013. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews* 8(8).

Six Nations of the Grand River Territory. 2006. *Tsi Non:we Ionnakeratstha Ona:grahsta' Maternal and Child Centre.* http://www.snhs.ca/bcBackground.htm, as of February 2015.

Sutton W. 1996. Saga of the Toronto Birth Centre: an engagement with government. *Health Law Journal* 4:151-178.

Vadeboncoeur H. 2004. Delaying legislation: the Quebec experiment. In *Reconceiving midwifery*, ed. Bourgeault IL, Benoit C, Davis-Floyd R. Kingston: McGill-Queen's Press-MQUP.