



Modern Maternity Care in Canada

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Georgina, a mother of Mi'kmaq heritage, is in the last stage of her pregnancy. Reluctantly, she is preparing to leave her home community of Port-aux-Basques, located on the southwestern tip of Newfoundland, to give birth in the only remaining maternity hospital in her health region, the Western Memorial Regional Hospital in Corner Brook, 220 kilometres away from her family and friends. Her chances of having a maternity doctor or midwife she knows attend her birth are slim to none, and there is a 30% chance that her baby will be delivered by Caesarean section.

Millennium Development Goal 5, to improve maternal health, is one of the United Nations Millennium Development Goals (MDGs). Of the eight MDGs, the least progress has been made toward *the right of every woman to the best possible maternity care*. Indigenous, poor and rural and remote women such as Georgina are especially compromised. While Canada made major strides throughout the 20th century to improve maternal health and build a universal maternity care system, many shortcomings remain, including but not limited to the medicalization of childbirth and inequitable access to maternity providers.

History of childbirth in Canada

Pregnancy and childbirth are significant life events in all cultures. In earlier times, midwives were the primary

care providers. Care during pregnancy typically took place in the local community and birth occurred in the home.

Medicalization of maternity care in Canada, while significantly predating the development of the modern welfare state, became enshrined and solidified within

Maternal Mortality in Canada

Maternal deaths rose in Canada from 6 to 11 per 100,000 births between 1990 and 2013.

In 2013, UNICEF ranked Canada 22nd out of 29 high-income countries for infant mortality rates, with the rate substantially higher among Indigenous peoples.

CAESAREAN SECTION RATES IN CANADA, 2001 TO 2013 (%)

	2001	2003	2005	2007	2009	2011	2013
Canada	22.5	24.8	26.3	26.7	26.8	27.1	27.3
NL	26.6	27.9	30.1	30.3	31.5	30.6	31.1
PE	27.9	30.3	29.8	31.7	30.4	28.9	31.3
NS	25.3	27.6	28.0	26.8	27.2	26.5	27.1
NB	26.6	28.6	28.7	28.0	28.9	27.3	27.4
QC	19.5	21.5	22.9	23.3	23.3	23.6	24.2
ON	22.9	26.0	27.7	28.1	28.4	28.6	28.0
MB	18.2	19.9	21.3	20.1	20.2	21.4	21.6
SK	18.4	20.1	21.1	21.7	22.1	23.1	23.5
AB	22.5	24.4	26.3	27.9	27.4	27.4	28.9
BC	27.1	28.7	30.4	31.3	31.1	32.0	32.9
YK	25.9	24.3	27.2	22.9	23.0	25.0	23.2
NT	23.3	24.2	24.8	19.8	19.6	21.9	20.1
NU	9.2	9.5	8.2	6.8	7.8	11.3	9.9

Source: Canadian Institute for Health Information (CIHI).

the package of policies and regulations that accompanied the adoption of universal health care, known as “medicare,” which was implemented and formally adopted in 1972.

While Canada’s health care model is often referred to as a simple *single payer health care system*, funding and delivery of insured services are in fact much more complex. They involve federal and provincial/territorial governments, community services, private insurance companies and individuals.

Most physicians work in private practice, with their services paid from the provincial/territorial insurance plans. Funding for the insurance plans comes from the general revenues of the provinces/territories, with additional transfer payments from the federal government through the Canada Health and Social Transfer or, more recently, the Canada Health Transfer.

Under medicare, only *physician-provided* maternity care services were covered by the public health care system, which resulted in shifting the role of midwives (women) to medical doctors (mostly men). In the publicly funded health care system that was created, physicians also retained their right to remain private entrepreneurs, establishing their practices wherever they deemed appropriate.

The system created through medicare did not address the pre-existing disparity in the availability of physician services and solidified the hospital as the control centre of the maternity care system. Due to concerns about modesty and fear of contagion, it also excluded partners and other kin from participating in the age-old event of childbirth.

Modern childbirth in Canada

By the early 1980s, virtually all women across the country were delivering their babies in regional hospitals, attended by a maternity physician or obstetrician and assisted by obstetrical nurses. But these institutional changes left women lonely and new fathers sidelined. Research shows that women who have the support of a partner during labour require less pain relief and feel more positive about the birth. As research began to show the importance of healthy parent-child attachment, the health care system responded by allowing partners to be active participants in the birthing process. Partners today are present for the majority of births, taking on a greater role not only in these first moments of their children’s lives, but also with child rearing and household management in the years that follow.¹

Canada currently boasts the lowest *maternal* mortality rate on the American continent, reflecting improvements throughout the 20th century in women’s education, their nutrition, control of their fertility and universal coverage of physician services. Yet maternal deaths rose in Canada from 6 to 11 per 100,000 births between 1990 and 2013. By contrast, Japan and a number of European countries today have mortality rates half the Canadian rate or lower. Equally disconcerting, in 2013, UNICEF ranked Canada 22nd out of 29 high-income countries for *infant* mortality rates, with the rate substantially higher among Indigenous peoples.

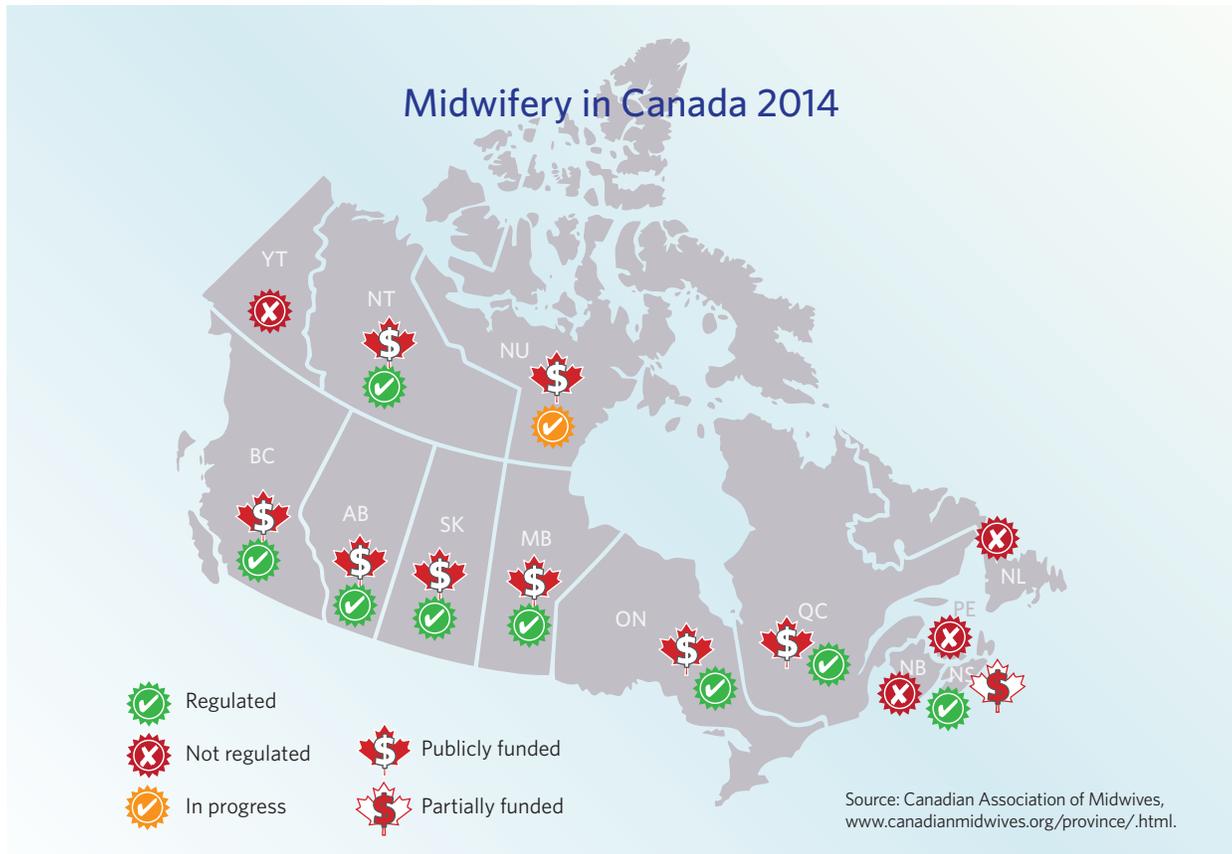
In recent decades, the number of family doctors involved in maternity care delivery has significantly

declined, as has the number of hospitals offering maternity care services. At the same time, the percentage of deliveries attended by obstetricians has increased substantially; for example, obstetricians currently attend 80% of hospital births in Ontario. Caesarean section rates have also steadily increased, with the total national rate increasing from 17.6% in 1995 to 22.5% in 2001, and 27.3% in 2013 (see Table). The current rate of Caesarean section births ranges from a high of 32% in British Columbia and 31% in Newfoundland and Labrador to a low of 23.1% in Saskatchewan and 21.4% in Manitoba. According to the World Health Organization, Caesarean section rates below 10% indicate underuse of this life-saving procedure, while rates above 15% are deemed to show overuse. Overuse of Caesarean section has been linked to higher morbidity in mothers, including an increased risk for depression and post-traumatic stress, lower breastfeeding rates and a greater likelihood of future complications in pregnancy. Despite popular media images of maternal demand for Caesarean section, there is little evidence that the increase in the national rate in the last 20 years, and the even more surprising current cross-country variation, is based on mothers' demand for a convenient pain-free birth – the so-called "too push to push" argument.

Modern midwifery in Canada

Beginning with Ontario, British Columbia and Quebec in the 1990s, and spreading across most other regions since, midwives have received formal education and become regulated, and their services have been publicly funded. Yet the occupation still remains unregulated and unfunded in Newfoundland and Labrador, Yukon, Prince Edward Island and New Brunswick. Moreover, only 9% of births in Canada are currently attended by a midwife. While the percentage of midwife-attended births is higher in some regions (e.g., 19% in British Columbia), the demand outstrips the supply, with a substantial proportion of women in all parts of the country wanting access to a trained, publicly funded midwife but unable to find one.

Women with lower education, younger mothers, women without a partner and women living in rural and remote areas or socio-economically disadvantaged communities have the least access to publicly funded midwifery services. The Association of Ontario Midwives estimates that as many as 40% of women who want to see a midwife in Ontario are currently unable to find one, and women in other provinces are also experiencing frustration trying to find midwifery care. Following developments in



Quebec and Manitoba, Ontario recently funded two free-standing, midwifery-led birth centres. Yet this option is not available for many non-Indigenous and Indigenous women, such as Georgina mentioned above, who instead experience loneliness, disconnection from their local maternity traditions and isolation from family; the overall result is “stressful births.”²

Modern postpartum care in Canada

The length of time Canadian women spend in hospital following childbirth has decreased dramatically during the modern period, from a mean of five days in 1984–85 to just less than two days after vaginal delivery today. Hospital stays are costly; early hospital discharge for mothers and their newborns helps administrators control or reduce obstetrical care expenditures. For some women with strong support systems and access to publicly funded physician or midwifery services, early discharge from hospital is usually a welcome occasion.

As in earlier times, family support can be crucial in the postpartum period. Fathers and/or partners across Canada, with the support of parental leave policies, are playing a much bigger role after childbirth than in previous generations – a shift in family roles that continues to this day. According to Statistics Canada, 31% of recent fathers across the country claimed or intended to take parental leave in 2013 – a significant increase from 3% in 2000. The rate is much higher in Quebec, particularly since the introduction of the Quebec Parental Insurance Plan (QPIP), which is the only plan in the country that specifically provides *paternity* leave. Since the introduction of QPIP in 2006, uptake has more than tripled, from 28% in 2005 to 83% in 2013.

But for women without these familial and formal options, the result can lead to negative health outcomes for themselves and their infants. Provincial and territorial health care systems cover a limited range of postnatal care services. At the federal level, this has traditionally been restricted to the provision of informational supports by the provinces and the publication of national guidelines for maternity and newborn care. In some regions, an optional home visit by either a public health nurse or a lay home visitor is still available, while in other regions, services following discharge from hospital have been reduced to a telephone call to a new mother from a public health nurse.

Privately delivered postnatal services have emerged to fill this care gap. There currently exist no published research studies on the for-profit postnatal services that currently exist in Canada. Postpartum doulas who advertise online often propose tangible, high-intensity supports such as newborn care, breast- and bottle-feeding support, child-minding services, meal preparation, household chores and so on.

Unfortunately, relatively high out-of-pocket costs make these forms of support accessible only to those who are able to pay for them. Doulas who advertise online generally charge around \$25 per hour, or anywhere from \$100 to \$1,000 for overnight or week-long package deals, respectively. Research studies in this emerging area of practice are needed to determine the scope of practice and outcomes for mothers and their families. There is currently no information available on user demographics, patterns of use or outcomes associated with these forms of commodified care, though such information would offer insight into the types and levels of unmet needs that exist.³

The future of maternity care in Canada

As is clear from our history, midwives were the main maternity care providers in what is now Canada before the arrival of European settlers and up to the modern period. Midwives provided not only crucial technical care, but also social support to enhance the health and well-being of women and babies in homes and local communities. Modernization of maternity care involved the move from midwives and natural childbirth into the medicalization of childbirth, with obstetricians replacing family doctors as the maternity providers, and labour and delivery restricted to fewer and fewer hospitals. High Caesarean rates and the associated unnecessary morbidity for mothers is one outcome of this modern system of care. The return to midwifery and the integration of midwives into our health care system have thus far been insufficient, as midwives are too few in number, they are concentrated in urban centres and their services are not equally available in all provinces/territories.

As the country works toward achieving MDG 5, as families become more complex and partners become more involved in childbirth and child care, and as we have access to more research on how to increase positive health outcomes for mothers and newborns, the health care system will continue to evolve and adapt to ensure the availability and effectiveness of maternity care in our communities from coast to coast to coast. ♡

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¹ Cecilia Benoit et al., “Medical Dominance and Neoliberalisation in Maternal Care Provision: The Evidence from Canada and Australia,” *Social Science & Medicine*, 71:3 (August 2010), accessed August 24, 2015. <http://bit.ly/1Jv2r5j>.

² Cecilia Benoit et al., “Maternity Care as a Global Health Policy Issue,” *The Palgrave International Handbook of Healthcare Policy and Governance*, Ellen Kuhlmann, Robert H. Blank, Ivy Lynn Bourgeault and Claus Wendt (Eds.). Basingstoke: Palgrave, 2015. <http://bit.ly/1NPiir>.

³ Cecilia Benoit et al., “Privatisation & Marketisation of Post-birth Care: The Hidden Cost for New Mothers,” *International Journal for Equity in Health*, 11:1 (October 2012). <http://bit.ly/1ikd1BS>.