

MATERNITY CARE NOW

Pregnancy, birth and newborn are all words that, for most people, evoke positive feelings about the joy and happiness that a new child brings. Unfortunately, for an increasing number of women in Ontario, the words also call to mind the struggles that they face obtaining care, in navigating through a complex health care system and the uncertainty and lack of trust they feel dealing with unknown service providers.

“I found out just a couple of weeks before my expected date of delivery that my local hospital, the one I planned to give birth in, was scheduled to close the weekend that I was due...it was very stressful for me not to know where I would end up giving birth – it all depended on when my labour started. There are enough unknowns about an impending birth without the added stress of where the birthplace will be – especially for those of us whose labours tend to be quite short.”

(Focus group participant - Integrated Maternity Care in Rural and Remote Communities project).

Maternity care services are “the foundation for the subsequent health of mothers, babies and their families”.¹

The scope of maternity care services in Ontario includes approximately 40% of all live births in Canada² with the number of births expected to rise in the next 25 years from approximately 131,000 births annually in 2003 to 157,000.³ Maternity care is a leading reason for hospital admission.⁴ Maternity care services touch virtually every family in every region of Ontario. The success of these services – from pre-conception education to prenatal support to post-natal care – has lifelong implications for the health of neonates as they become adults, for women, and for the lives of their families and communities.⁵

In Ontario, the impact of these services on the health status of our population, the lives and functioning of families, the long-term costs of health services in terms of issues and the overall economic and social health of our society is not routinely measured or evaluated. Ontario’s health system

Quick Facts from Ontario

- Maternity care comprises almost a year of services from preconception to 6-8 weeks after the birth for women and newborns
- Cost of maternity care is over \$1B annually
- 130,927 babies were born in Ontario in 2003⁴
- Over 100 hospitals provide maternity care (OMCEP Hospital Survey, 2005 – Appendix F)
- 80% of births are in 34% of hospitals (MOHLTC)
- The remaining 66% of hospitals provide care for 20% of births (MOHLTC)
- Approximately 1.4% of babies are born at home each year (1,883 in 2004-05) (MOHLTC, Ontario Midwifery Program)
- Current Caesarean section rate is 26%⁴
- 70-80% of pregnancies are considered low-risk or normal (WHO)
- Approximately 82% of births are attended by obstetricians, 20% by family physicians and 7% by midwives (some births are attended by more than one)⁵⁸
- 5.7% of nurses self identify as providing maternity care (CNO)

spends over one billion dollars a year^c on maternity care services, yet there have been no province-wide policies or regular reports on access, distribution or effectiveness of these services. There is a general lack of population health policy for the system as a whole, with current policies concentrating on services by individual provider groups only.

Other provinces, including British Columbia, Alberta, Nova Scotia and Prince Edward Island have established provincial strategies to provide a framework for the coordination and delivery of maternity care⁶⁻⁹ and several provinces have commissioned recent reviews of their maternity care systems in response to evidence citing a maternity care ‘crisis’.¹⁰⁻¹² The Society of Obstetricians and Gynecologists of Canada, among other national maternity care stakeholders, has also characterized the current state of Canada’s maternity care health human resources as ‘in crisis’.¹³

What Do We Mean By Crisis?

As is documented throughout this report and in our bibliography (Appendix B), the term “maternity care crisis” has been used by multiple national and provincial organizations and in professional and public literature to describe concerns about provider shortages, challenges in distribution of services and access to maternity care. Concern about a crisis in maternity care is the basis for this project¹⁴ and for several Primary Health Care Transition Fund projects currently focusing on maternity care due to report in 2006-07.¹⁵⁻¹⁸ International reports document concerns about shortages of maternity care providers and many countries have also done recent reviews of maternity care policy. We reviewed reports from the Netherlands,¹⁹ England,²⁰ Australia²¹ and Scotland.²²

OMCEP’s work showed that in Ontario at the current time providers and institutions have adapted and worked hard to continue to provide a high standard of care. There are limits, however, to the ability of the system to

The Canadian Institute of Health Information reports that Ontario’s share of Canada’s maternity care system comprises:

- 40% of Canada’s births
- 35% of nurses
- 58% of registered midwives*
- 41% of obstetrical specialists
- 34% of family physicians
- 37% of anaesthetists
- 40% of pediatricians
- 50% of nurse practitioners
- 6 of 15 Canadian academic health science centres

^c This estimate was developed using case costing information to extrapolate the amount spent by hospitals on maternity care. Added to this estimate were budgets for public health maternal and newborn programs, midwifery funding and liability insurance reimbursements for obstetricians, family physicians and midwives. This estimate represents a partial costing only. Blended budgets and an absence of explicit reports for many relevant ministry programs prevented OMCEP from developing a comprehensive inventory of maternal newborn health care expenditures.

* Although initiatives to integrate midwifery are underway in most provinces/territories, only Ontario, British Columbia, Manitoba and Quebec have a funded provincial midwifery system.

compensate – both the experience of panel members and our research indicates an increase in problems that signal a lack of access to care.

Anecdotal examples that were reported include lack of access to early prenatal care; an increase in preventable complications in late pregnancy and birth that are almost unheard of in systems with adequate prenatal care; intermittent or complete lack of access to maternity care in small numbers communities has meant that some women have had to travel unsafe distances and decrease in services to support breastfeeding and postpartum maternal and newborn well being. These issues will be discussed in more detail throughout the report.

Our concerns about the challenges facing maternity care in Ontario should not be seen as an argument in favour of private health care. The panel believes firmly that the health of mothers and babies depends on a strong and accessible public system.

In our panel meetings and in meetings with stakeholders, the majority of individuals and organizations were very concerned about deterioration of services, but some may dispute whether we are facing a crisis at all. Some see the trend towards consolidation of services in fewer centres and a decreasing proportion of care provided by family physicians as an appropriate adaptation. Others feel we have underestimated the crisis and that the assumptions we have made do not adequately take into account patterns of retirement, work load preferences of newly graduating and predominantly female care providers, and the decline in services in rural and remote communities – all of which have serious implications for the future capacity of Ontario’s maternity care system.

We have suggested some important directions for evolution and change. Change is never a smooth process and we anticipate that there will be concern and some resistance among providers, but we are confident there is strong general support for our recommendations among all provider groups. In his article for the *Journal of Obstetrics and Gynaecology of Canada*, Sept 2005 SOGC president Michael Hellewa notes, “But the biggest barrier, in my judgment, lies within: we are afraid of change. We must have the courage and confidence to go beyond traditional habits and practices”.²³

The Continuum of Maternity Care Services

Maternity care involves far more than the services provided during labour and childbirth. In fact, maternity care occurs over a period of about one year. It begins with a focus on optimum health in the preconception period and preconception counselling and includes prenatal care, care during labour and birth (or intrapartum care) and services to both the woman and her newborn for six to eight weeks after birth (postpartum and neonatal care).

Currently, local maternity care in Ontario is delivered through an uneven mix of primary care, public health, specialty care, institutional care, community services, and mental health programs. There are often overlaps and gaps in service provision, especially for women who must travel significant distances or overcome barriers to obtain maternity care (OMCEP Focus Groups, 2005 – Appendix G).

Maternity Care Settings

Maternity care services are provided in a range of settings including physicians', midwives' and nurse practitioners' offices, hospitals, public health and community clinics and homes. The stakeholders OMCEP consulted report that, an increasing number of women resort to seeking care in walk-in clinics and emergency rooms without routine screening and regular follow-up (OMCEP Focus Groups, 2005 – Appendix G).

Intrapartum (birth) care is most often provided in one of the approximately 100 hospitals (OMCEP Hospital Survey, 2005 – Appendix F). A survey done by OMCEP of these institutions revealed an increasing number of these institutional services to also be under pressure (OMCEP Hospital Survey, 2005 – Appendix F):

- 5% have had a recent shut down of maternity services with the transfer of funds to other acute care services and the resultant transfer of women and babies to other centres
- 17% are experiencing a decrease in the number of providers for the service
- 70% experience a lack of consistent Caesarean section availability due to provider shortages
- Only 7% are above the provincial goal of >70% full-time nurses²⁴
- 26% are experiencing nursing shortages for maternity care

A small minority of births in Ontario (1.4% or 1,883 births in 2004-05) were assisted in the home setting by registered midwives.

Postpartum care is currently also spread across a variety of settings including hospital, clinic and home settings and is provided by obstetricians (for women), paediatricians (for newborns), family physicians, midwives, registered nurses and primary health care nurse practitioners. Our focus groups drew attention to the fact that the lack of availability of family physicians can leave families to seek newborn care at walk-in clinics and emergency rooms. This issue needs further investigation.

“I went to see the doctor twice in “CITY A” in the emergency department. He was very nice to me and told me my due date, arranged an ultrasound and blood work, but he was supposed to get me an appointment at the clinic and I guess he couldn't get it set up”

-From a 17 year old woman who had minimal prenatal care, OMCEP focus group

Fewer Hospitals Providing Maternity Care Services

Over the past 10 years, hospitals across Ontario have tended to consolidate services in a smaller number of sites in an attempt to improve efficiency and reduce costs. It is widely accepted that a well-organized network of high-risk perinatal services can contribute to better outcomes, but our report will outline the ways in which there can also be negative effects on access when low-risk services are consolidated far from where women live. In

some cases, hospitals report that they have closed birthing services or other essential services to balance hospital budgets (OMCEP Hospital Survey, 2005 – Appendix F).

Not all cuts result in hospitals closing their intrapartum units. Rather, some hospitals are opting to maintain birthing services and reduce other elements of care (including dedicated ‘maternity’ nursing care, lactation support programs, prenatal education, social work and mental health services) that collectively contribute to quality maternity care, shorter hospital stays and better outcomes for women and newborns. Divestment of non-acute maternity care programs by hospitals, without reinvestment in community programs has led to reports of uncoordinated maternity care and gaps in many services (OMCEP Focus Groups, 2005 – Appendix G). Focus group participants expressed concern that lack of access to preventative health programs, such as prenatal education, nutrition and breastfeeding support, is leading to greater pressure on hospitals for preventable acute care population health needs.

Consolidation and access to care issues are not new. In the past, these issues have primarily affected small and rural communities. As early as the 1990s, there was a sharp drop in access to maternity care, particularly in small communities and rural areas.^{25,26} By 2002, new closures and limits on the number of women booked to give birth meant that small Ontario hospitals were offering less maternity care.¹⁴ Now, in 2006, intermittent closures are affecting larger centres including: Toronto, Pembroke, Cornwall and Sault Ste. Marie.

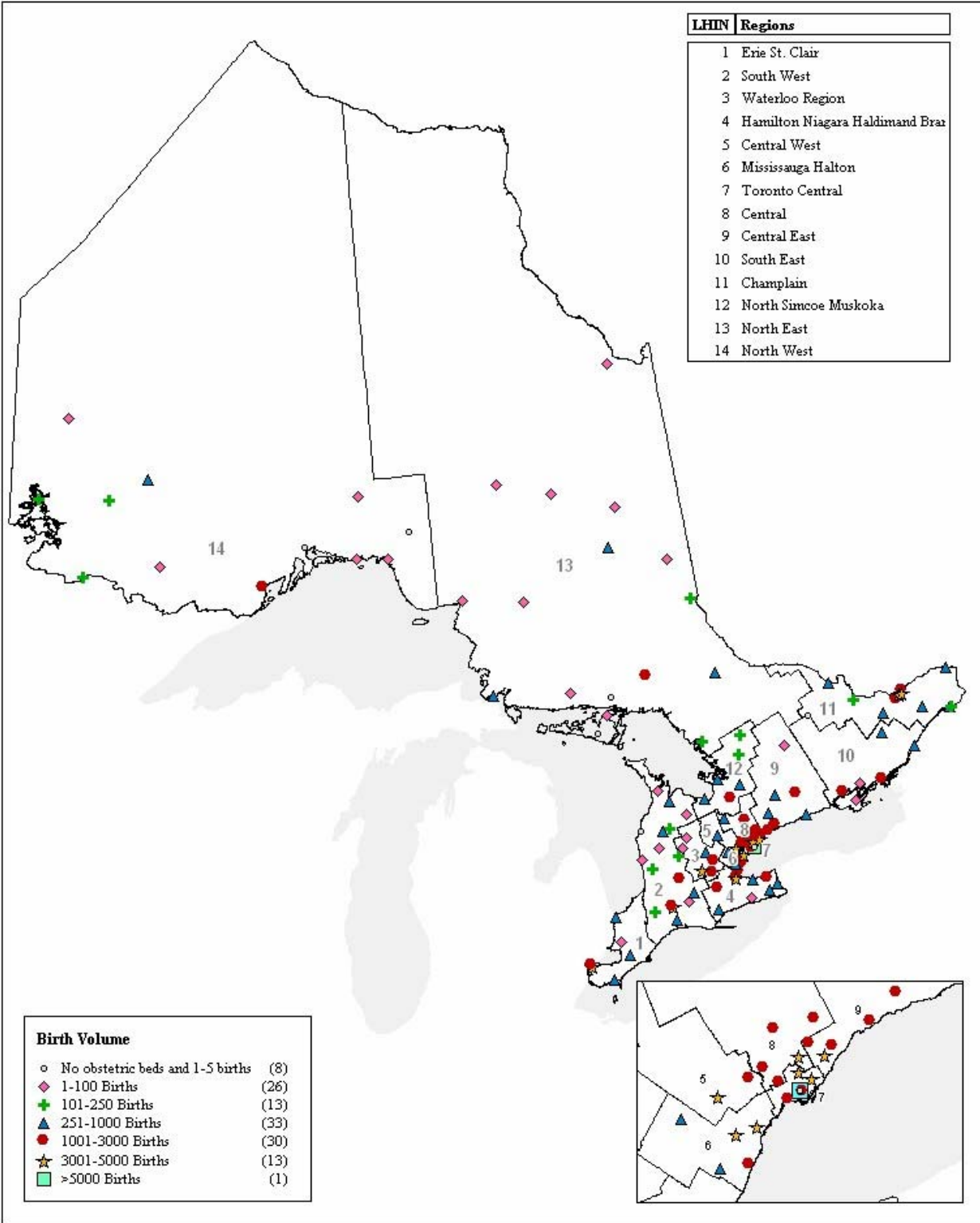
Evidence from Canada and other countries indicates that women who are required to travel for care during pregnancy have increased morbidity.²⁷⁻³⁰ Figure 1 illustrates the context of Ontario’s vast geography and the large proportion of Ontario hospitals that provide low-volume intrapartum services.

Figure 1

OMCEP developed the following map in August 2005 to show the provincial distribution of births in hospitals and the vast geography, including the most urban and some of the most remote in Canada, across which intrapartum maternity care services are provided. In the absence of a provincial maternity care plan, hospitals decide independently whether to maintain birthing services. The contrast within Ontario between densely urban and extremely remote communities highlights the differing needs of the various regions of our province and the challenges we face to provide access to consistent, quality services. About one third of Ontario’s hospitals provide services for about 80% of births in a concentrated geographic region with volumes ranging from 1000- 7000 births per year. The other two-thirds of hospitals provide services to the vast less populated regions of Ontario, most with volumes less than 1000 births per year. About one quarter of hospitals providing intrapartum care in Ontario have volumes of less than 100 births per year.

An annual report including maps like the one above, and others to show access to prenatal care, postpartum care and distribution of professionals could be a valuable tool to assist hospitals, Local Health Integration Networks and the Province to monitor and maintain a provincial maternity care plan for equitable, quality services. Currently, our health system does not maintain ongoing tools like these in Ontario.

Figure 1 - Ontario Hospitals with Intrapartum Services by Birth Volume 2004-05



Source: Ontario Midwifery Program, April 2006

Low-Volume Maternity Care – A Safe Model of Care

OMCEP undertook a review of the literature with respect to hospital services in low-volume communities. Like the rest of Canada, Ontario's geography and demographics mean that low-volume maternity care is an important but fragile part of Ontario's health care system.

Almost two-thirds of Canadian hospitals have fewer than 500 births per year and nearly one-third have fewer than 100 births per year.³¹ For many years, maternity care has been provided in the majority of these communities by family physicians with the assistance of registered nurses.³² Some of the larger communities have benefited from the services of obstetricians, often working in ones and twos, possibly with locum relief at the weekends or for holidays only. Increasingly, registered midwives are providing service in some rural communities in Ontario, British Columbia, Alberta, Manitoba, Quebec and the Northwest Territories.

There is evidence to indicate that maintaining maternity service provision in rural and remote communities improves obstetric and neonatal outcomes. Some of the earliest evidence was provided in 1984 by Black and Fyfe's review of perinatal loss rates in Ontario hospitals. They concluded that small hospitals offering Level I services had equivalent or in many cases lower rates of perinatal loss than hospitals providing care for >1000 births per year.³³ A similar conclusion was also drawn by Woollard and Hays in Australia in a study of nearly 6000 rural births compared with 88,000 total births in New South Wales during a one year period in 1990-91.³⁴ They did, however, raise serious concerns about the birth outcomes in hospitals without any planned maternity services, noting a high proportion of low birth-weight infants, stillbirths and neonatal deaths occurring in small hospitals without obstetric facilities. The risk here appears to be associated, not with the size of the hospital, but with the absence of the full continuum of maternity care services.

“The fact that some women continue to present to these hospitals in labour is testimony to the determination of some rural women to have their baby near home. In view of the poor obstetric outcomes in these hospitals, the policy of closing smaller units may have to be reconsidered.”³⁴

More recent evidence from a review of birth outcomes for women delivering in Australian hospitals over a 3-year period demonstrates that lower hospital volume is not associated with adverse outcomes for low-risk women. Hospitals were categorized according to births per year as <100 births, 100-500 births, 501-1000, 1001-2000, and >2000. Neonatal death was less likely in hospitals with less than 2000 births per year regardless of parity. Given appropriate prenatal referral of women with medical and obstetric complications to the larger centres, this is not surprising.³⁵

Evidence from New Zealand, B.C., Nova Scotia and the U.S. also supports the safety of local maternity services for low-risk women within a regionalized perinatal system with an efficient intrapartum transfer system.^{27,36-38} Concerns have been raised about slightly increased neonatal mortality rates associated with the use of low-volume delivery units

by Moster et al³⁹ in Norway and Heller et al in Germany.⁴⁰ These findings were not supported in a later study by Finnstrom et al of 1.5 million births in Sweden.⁴¹

“As expected, the infant mortality at the smallest delivery hospitals was lowest, although not statistically significant, because a certain number of risk mothers are referred before delivery to larger units.”⁴¹

Nesbitt reviewed the birth outcomes of all rural Washington state women in 1986, stratified by low, medium and high-outflow communities. In communities where more than two-thirds of the local women give birth outside of the local community, the perinatal mortality and morbidity statistics worsen for all women from that community, regardless of place of delivery.

“These women are more likely to have complicated labor and premature deliveries, and their infants are more likely to have longer and more expensive hospital stays than the children of their rural counterparts who deliver in local facilities communities with greater access to care.”²⁷

Nesbitt also noted an association between high-outflow communities and loss of obstetrical service. While there were 13 high-outflow communities with obstetrical care at the outset of the study, only eight remained at the end of the study period. An additional three of the eight suspended their services in the two years following the study, citing the decision of local physicians to discontinue offering obstetric services. The decline in availability of maternity care services in small communities has been well documented in the Canadian literature.^{25,26,42} In addition, concerns have been raised regarding the future of Ontario’s obstetric human resources.^{14,43-45}

There is wide support for the provision of maternity care for healthy women in their home communities. The Society of Rural Physicians of Canada and Society of Obstetricians and Gynaecologists of Canada’s Joint Position Paper on Rural Maternity Care, the B.C. Reproductive Care Program consensus conference, and the Future of Maternity Care in Canada Conference in 2000 have all indicated that there exists a shared goal to support practitioners in providing local maternity care.⁴⁶⁻⁴⁸ The SOGC supports the provision of health services as close to home as possible for Aboriginal peoples and the training of aboriginal midwives to work in local communities.⁴⁹ Klein et al have identified the essential role that maternity services provide in maintaining the economic and functional sustainability of rural communities.⁵⁰ Kornelsen and Grzybowski provide some thoughtful recommendations to support the strengthening of local maternity services.⁵¹ Suggestions have been offered in the literature that collaborative practice may be a useful model in low-volume communities^{28,52,53} in addition to the variety of creative solutions that have been developed by family physicians and midwives working in rural and remote communities.⁵⁴

Panel members report that there is a growing consensus in Ontario among rural maternity care providers that women should not travel more than 30-60 minutes to a low-risk obstetrical unit. This is based on the need for urgent care for short labours, early

assessment of labour risk when distant from specialty services and consistency with the principle that services are best provided close to home.

Maternity Care Providers

Maternity care is provided by a number of different health professionals based on their regulated scopes of practice and acquired skills, and on each woman's needs and choice. Different professionals, such as public health nurses, primary health care nurse practitioners, midwives, and physicians, can provide services such as prenatal care and postpartum care. Other services, such as deliveries, can only be done by providers who have specialized training, such as family physicians, midwives, and obstetricians. Some highly specialized services, such as operative deliveries can only be performed by physicians, with certain services reserved for obstetrical specialists only.

The specialized skills of the other care providers (referred to above right) make them valuable contributors for a discreet portion of the continuum of care (such as for newborn care) or in certain cases only (such as when transport or anaesthesia are needed), or in a

supportive care capacity to families (such as doulas).

Maternity Care Team

Acute Care Nurse Practitioners
Alternative Medicine Providers
Anaesthesia Staff
Doulas
Family Physicians
Lactation Consultants
Midwives
Nurse Practitioners, Primary and Acute Care
Obstetricians
Paediatricians
Perinatal Mental Health Care Providers
Primary Health Care Nurse Practitioners
Public Health Nurses
Respiratory Therapists
Social Workers
Surgeons
Transport Staff

Nurses and Maternity Care

The maternity care system relies heavily on the presence and contribution of nurses, who provide a wide scope of maternity care services throughout the entire continuum of care. Nurses provide care to both mothers and newborns at the vast majority of births in the province as part of a team with either a physician or in some cases, a midwife. They are involved in preconception counselling as primary health care nurse practitioners and as clinical nurse specialists working with genetic screening clinics. They may work with physicians, or alone as primary care nurse practitioners, to provide prenatal assessments and are often employed as prenatal educators. Their role in the hospital labour and delivery units, postpartum units and newborn nurseries is the backbone of a hospital system in which staffing pressures pervade and are amplified due to the unpredictable timing of births.

We know the number of registered nurses who are employed in nursing in Ontario only through the data provided by the College of Nurses of Ontario each year as they register their intention to practice in the following year.⁵⁵ In 2004, of the total 86,099 registered nurses who identified that they were employed in nursing, 4,921 identified that they

provided direct care in maternal newborn care. OMCEP could not ascertain how many of these nurses provide intrapartum care vs. working exclusively in neonatal nurseries, postpartum units or other areas of general duty nursing. We could find no data on services provided by nurses to women in the community setting such as prenatal and postpartum care.

The percent of registered nurses who self-identify as providing maternity care has ranged from a high of 6% in 1997 to 5.3% in 2003. A rise is seen in 2004 to 5.7%. Only registered nurses who specified, “direct care maternal newborn” on College of Nurses of Ontario documents were included. This total therefore does not include those who indicated that they work in several clinical areas, which is the case for most rural registered nurses.⁵⁵

The OMCEP Hospital Survey tried to identify how many nurses worked in intrapartum care. The number appeared to have little correlation compared to the number of births in any given unit. There was wide variation between sites of equal size and acuity. Of interest, only 51% of all the maternity care nurses identified in the OMCEP Hospital Survey are working full-time, compared to the overall provincial average of 59%. This is well below the provincial target of 70% full-time employment for nurses in Ontario.

Nurses identify significant barriers to maternity nursing related to employment pressures in the hospital setting. It is difficult for hospitals to recruit and maintain a pool of experienced maternity care nurses when new nurses have had little or no exposure to maternity nursing during their initial education programs. Many hospitals require intensive education courses to be completed either prior to or as a condition of employment, e.g., in fetal surveillance, labour support, and others. Hospitals reported that it can be challenging to maintain certifications for maternity care nurses in the absence of a coordinated regional approach to professional development.

To retain maternity nurses, there need to be opportunities for ongoing education and recognition that maternity nursing requires a specialized skill set. The rapid turnover of nursing staff due to lack of job security in hospitals creates a significant teaching and mentoring burden on experienced maternity care nursing staff in addition to their regular workload (OMCEP Focus Groups, 2005 – Appendix G).

The attractiveness of maternity care nursing as a career option is also affected by the fact that the value of their contribution as part of the maternity care team is not routinely recognized or acknowledged. A prime example of the under-valued role that maternity nurses are accorded is illustrated in *Giving Birth in Canada: Providers of Maternity and Infant Care*.⁵⁶ Nurses’ contributions were confined to one paragraph although nurses attend the vast majority of births in Canada.

Nurses are not practising to their full scope in some settings. In other settings, nurses express concerns about maintaining competence, particularly in low volume intrapartum practice. In many small community and rural hospitals maternity nurses are required to work in other areas as well. In birthing hospitals with up to 2,000 births per year (OMCEP Hospital Survey, 2005 – Appendix F), nurses reported working in multiple units. OMCEP focus group nurses reported working in up to four different units.

Research evidence⁵⁷ and OMCEP consultations indicate that lack of full-time employment and low case numbers each year contributed to nurses’ decisions to seek employment in other sectors of health care. Several managers informed OMCEP

members that an inability to recruit and retain maternity nurses was a constraint to being able to offer maternity services, particularly in small communities.

In the latest Nursing Plan Report from the Ministry of Health and Long-Term Care⁵⁸, 73% of Ontario's Registered Nurses were between the ages of 42-48 years and 14% were over 55 years of age. This represents compelling need to consider retention and succession planning strategies for these skilled 'late career' nurses.

Obstetricians and Maternity Care

Obstetrical specialists attend the vast majority of births in Ontario, both for healthy women and women with pregnancy complications, and a larger proportion of births than in any other province in Canada.⁵⁶ Obstetricians balance the demands to maintain provision of intrapartum services in hospitals, their own clinic practices and a range of gynaecological services including surgery. In Ontario, approximately 75% of obstetrician-gynaecologists regularly attend births as part of their practice, with the other 25% specializing in other aspects of women's health care. For the last decade, the number of obstetrician-gynaecologists regularly attending births has been relatively stable at slightly under 500.⁵⁹

The shift away from family physicians providing intrapartum maternity care services has affected patterns of practice among Ontario's obstetrical specialists. Obstetricians are responding to shortages of other maternity care providers by increasing the number of women they see and, in areas where recruitment has become more challenging, by increasing the amount of time spent on-call. Between 1999 and 2003, the number of births attended by the average obstetrician increased by 10% from 200 per year to 220.⁵⁹ The range in intrapartum activity by obstetricians is wide, with some obstetricians attending 500 births or more in a year, in some cases in solo practice (OMCEP Hospital Survey, 2005 – Appendix F). Without succession planning, the retirement or temporary absence of one obstetrician can result in the suspension or closure of birth services for an entire community. The group of obstetricians providing most of the birthing services in Ontario are between the ages of 45 and 55.⁵⁹

“When the OB goes on holiday, women must birth elsewhere.”

- Participant (Integrated Maternity Care in Rural and Remote Communities project)

Some see a trend towards younger obstetricians increasingly sub-specializing in areas of obstetrics and gynaecologic practice such as uro-gynaecology, oncology, imaging, fertility and maternal-fetal medicine.⁶⁰ Others we consulted with reported challenges recruiting into the sub-specialities. More study is needed to determine the impact of obstetric career choices on provider distribution, prenatal and intrapartum care.

“It’s a huge difference whether we take someone on from 28-weeks and look after the third trimester and give them permanent care vs. doing everything from the first prenatal visit to the post partum visit 6-weeks later. And with the number of obstetricians not really increasing in Canada, its going to be a huge burden so its not just deliveries, it’s prenatal care as well.”

From an Ontario obstetrician, MCP² focus group

Family Physicians and Maternity Care

Delivering babies used to be an integral and highly valued part of most family physicians’ practice, but that has changed. Over the past 25 years, Ontario has seen a significant drop in the proportion of births attended by family physicians. This is part of a decades-long trend for general and family practitioners – the leading providers of primary health services – to withdraw from intrapartum care, as well as maternal and newborn care.^{42,61}

The number of family physicians attending births decreased by 43% from 1,944 in 1992 to 1,105 in 1999.⁶² By 2003-04, only 731 or 6.9% of family physicians billed OHIP for more than one birth.⁶³

The proportion of total births attended by family physicians has also declined. In 1979-80, family physicians attended 41.2% of Ontario deliveries. By 1988-90, that proportion had dropped to 26.4%;⁶² it had dropped to under 15% by 2003-04.⁶³ These figures taken from the OHIP database reflect the births for which family physicians were the only care provider who billed. This does not reflect births attended by both family physicians and obstetricians. OMCEP’s analysis indicates that if OHIP billing codes P006 plus P009 are considered, the proportion of family physician-attended births is more accurately represented as approximately 20% in Ontario.

Family physicians’ declining participation in intrapartum care reflects their desire for more work/life balance, concerns about maintaining their competency in obstetrics, and concerns about liability.^{61,64-67} The move away from maternity care is also related to an overall shortage of family physicians in Ontario, increasing demands on their time, and perceptions that some hospitals do not support or value their ongoing involvement in maternity care.⁶⁸ Compounding the problem is the fact that family medicine trainees are more and more likely to enter residency training without an interest in intrapartum care.⁶⁹ They are exposed to few academic role models who provide full spectrum maternity care and thus, they graduate, without experiencing the richness which maternity care brings to a family practice.

A core group of family physicians continue to make intrapartum care part of their practice. These physicians are currently attending an average of 20 births per year per practitioner.⁵⁹ Further studies are required to determine whether family physician withdrawal from intrapartum care is secondarily resulting in withdrawal from prenatal and hospital newborn care.

Midwives and Maternity Care

Since the regulation of the profession of midwifery in 1993, and the establishment of three baccalaureate education programs at Laurentian, McMaster and Ryerson universities and a bridging project for internationally prepared midwives, Ontario has seen a steady increase in the number of registered midwives from 70 in 1994 to 330 in 2006.⁷⁰

During our consultations we found that the scope and model of practice of midwifery is often unfamiliar. Like other health professions, midwives are governed by an autonomous regulatory body, the College of Midwives of Ontario that sets out the profession's scope and maintains standards of practice.⁷¹

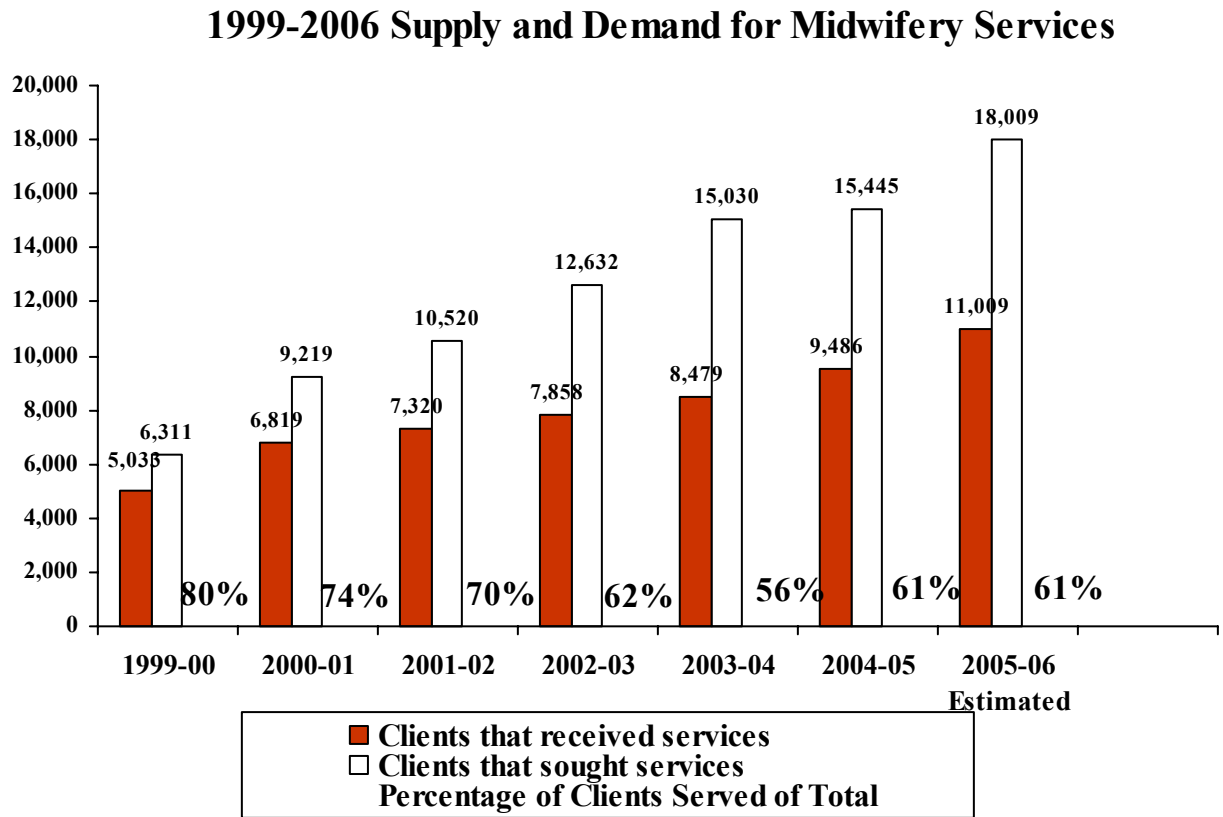
The midwifery scope of practice includes comprehensive maternity care services to healthy women and newborns throughout pregnancy, birth and up to six weeks postpartum; including the management of vaginal births on the midwife's own responsibility. Regulations govern the drugs, lab tests and ultrasound services that midwives can prescribe in the care of healthy women and newborns. Standards of practice set out the circumstances in which midwives are required to consult and/or transfer care to physicians.⁷²

Midwives typically work in group practices of between 2-10 midwives and share clients among a small call group. Approximately 78% of midwifery clients choose to give birth in the hospital setting with 22% opting for home birth.⁷⁰ Since regulation, midwives have obtained admitting privileges at about 2/3 of Ontario birthing hospitals. Each midwife coordinates the care for an average of 40 women per year, with each course of care typically comprising pregnancy, labour, birth and postpartum care and participates in on-call coverage of all of the women cared for by her practice group. Midwives attend births in pairs, together providing a similarly comprehensive set of services to the physician-nurse team. The role of midwives cannot be understood by direct comparison to either physicians or nurses as it combines elements of both roles. Like physicians, midwives provide prenatal, intrapartum and postpartum care as the most responsible provider. Like nurses, midwives provide ongoing monitoring and support during labour and care for women and newborns in the immediate postpartum period.

The expansion of midwifery services offers women an alternative form of maternity care for low-risk pregnancies. It has also helped to mitigate some physician and nursing shortages, but there are not enough midwives in Ontario to meet the current demand for their services (Figure 2). In 2004-05, midwives were able to meet only 61% of demand^d.

^d The Ontario Midwifery Program, Ministry of Health and Long-Term Care, collects a list from midwifery funding agencies of the women who are unable to be taken into care by the local practice group. These data are submitted each quarter along with financial reports. The demand for midwifery services cannot be measured in large areas of the province that have no midwifery practice group.

Figure 2 – Supply and Demand for Midwifery Services



Despite the demand for their services, OMCEP heard that some midwives face local restrictions on their scope and their ability to obtain admitting privileges in hospitals. For example, the care of women who need induction, augmentation and epidural analgesia is included in the midwifery scope, after consultation with an appropriate specialist. However, despite recommendations from the College of Midwives of Ontario, some hospitals in Ontario require a transfer of care to a specialist for these and other common procedures.⁷³ Others place limits on the number of women for whom the midwives may provide hospital care, when other providers are not limited.

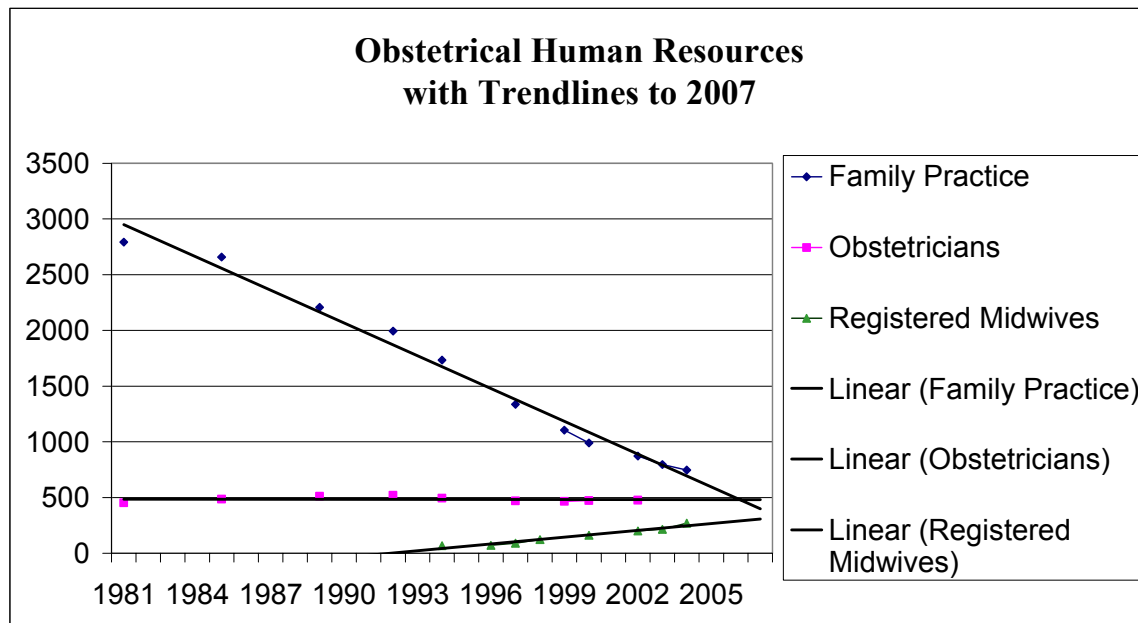
Focus group and stakeholder consultations revealed a lack of understanding about the midwifery scope and the contribution that midwives can make to the maternity care system in some settings. Preliminary reports from other maternity care projects confirm this finding.¹⁶ In several communities with a documented shortage of maternity care providers and a poor forecast for physician recruitment, OMCEP found an ongoing inability to obtain hospital privileges and/or integrate fully with the local maternity care provider team.⁷⁴ The panel was contacted by several hospital administrators looking for assistance in integrating midwives more fully into their institutions and in developing collaborative approaches between the professions.

“It’s a vicious circle: a lack of understanding of the midwifery scope leads to restrictive requirements for transfers of care [in addition to College of Midwives requirements]. The midwife never has a chance to prove her competence because care is transferred and she is not able to demonstrate her skills.”

OMCEP Focus Group Participant – Member of Hospital Maternity Unit Review Team

Figure 3 – Physician and Midwife Intrapartum Care Providers

As the below chart shows, a loss of family physicians to intrapartum care is resulting in a net loss of intrapartum maternity care providers in Ontario.



Adapted from Lofsky/Adamson, from Report to Babies Can't Wait, 2005⁵⁹

Current Issues in Education

Ontario has excellent health care education programs, but our consultations with educators and providers revealed concerns about lack of student exposure to maternity care generally and normal birth in particular. In addition, there is little coordination or integration among professional education programs, despite the fact that there is a strong trend – in maternity care and other areas of primary care in particular – towards inter and multi-professional teams.

Some rural focus group participants reported that confidence and competence in working in smaller hospitals is better fostered when providers learn to work in environments in which specialist back-up is not immediately available, i.e., not always in tertiary care centres.

Ironically, at a time when the maternity care workforce is needed more than ever to stabilize the system, maternity care curriculum in pre-licensure/undergraduate medical and nursing schools is under pressure. Some Ontario nursing schools no longer provide a core maternity care curriculum or clinical exposure to birth prior to graduation. Maternity care competencies have become increasingly seen as a specialized nursing skill set that is gathered as part of an elective clinical placement or on-the-job training (OMCEP Focus Groups, 2005 – Appendix G). Without early exposure to birth and maternal and newborn care, it is no surprise that fewer nurses appear to be attracted to a career in maternity care than in the past.

In the undergraduate medical school curriculum, students are exposed to one rotation as a clinical clerk under the obstetrics service on the labour floor. Family medicine residents

still have compulsory maternity care rotations; however, these are often within the department of obstetrics in academic health sciences centres where they are not exposed to family physician role models. Medical students and junior residents may actually “compete” to attend births when there is inadequate volume to meet the needs of all learners.

There is some evidence that recruitment and retention into maternity care is enhanced for those residents who are placed and later practice in smaller communities (15,000 and smaller).⁶⁹ Some studies point to the importance of family physician role models and exposure to enough births during residency.⁷⁵⁻⁷⁷ Attracting academic family physician role models in Family Medicine Residency Programs is challenging. In one study 16% of graduating residents from Family Medicine Residency Programs chose to offer pregnancy and birth care two years later but this varied from 2% for University of Western Ontario and 9% for University of Toronto graduates to 38% in Thunder Bay.⁶⁹

Across Canada and the U.S., it had been challenging to fill all of the obstetric residency spots available. According to a 2004 Canadian Institute of Health Information (CIHI) report⁵⁶ the number of resident positions “has been greater than the number filled over the past seven years”, however recruitment has improved and stabilized in the last two years.^{60,78,79}

“if they don’t learn together how can you expect them to work together”

*–OMCEP focus group participant
obstetrician and academic educator*

Stakeholders report lack of funding for subspecialty training in obstetrics and gynaecology (e.g. maternal fetal medicine, gynaecological oncology, uro-gynaecology and reproductive endocrinology and infertility) and challenges in recruitment into subspecialties.

The Ontario government has expanded Ontario medical schools, including the establishment of the Northern Medical School (NMS), adding 320 spaces in total since 1999. It has also increased residencies for International Medical Graduates (IMGs) from 24 to 200 entering annually. These initiatives may assist in recruitment and retention of medical maternity care providers. Recent reports indicate that between 24%-30%^{80,81} of medical students choose residencies in family practice and once in practice about 7% choose to provide maternity care in Ontario. Nationally about 45% of IMGs chose family medicine, but we did not find evidence about the number that chose to provide maternity care in this cohort.⁷⁹ About six percent of IMGs in Canada choose obstetrics and gynaecology residencies.

Although demand for midwifery services is out-pacing supply, the Ontario Midwifery Education Program reports that it has grown as far as is possible under its current funding arrangement. There are usually between 250-350 applicants for 60 spots. The number of graduates has increased incrementally to about 43 in 2006. The International Midwives Pre-registration Program has about 50 candidates for 20 spaces. About 15 international midwives graduate per year. The Midwifery Education Program was invited to submit a proposal for expansion by the Ministry of Training, Colleges and Universities in August 2004 but no decision has been made. The proposal includes an increase in inter-professional education and an advanced stream for nurses. At its current entrant class

size, the midwifery human resources pool will level off within approximately 20 years with new graduates merely replacing retiring providers.

Each of the professional programs reports challenges in finding an adequate volume of clinical placements. This can lead to an atmosphere of competition and can undermine collaborative relationships and inter-professional learning opportunities.

Although there is much enthusiasm for inter-professional education and some important examples of programs working together our consultations revealed many practical barriers to inter-professional teaching and learning. Inequitable funding for preceptorships across the professions and disparate curricula currently limit opportunities.

Stakeholders almost unanimously referred to programs such as MORE^{OB}, ALARM and ALSO^e, as important inter-professional continuing education courses as methods of creating the team for collaborative care.

Structural Supports for Maternity Care: Regulation, Funding and Liability Insurance

OMCEP consulted with regulators, representatives of professional associations and a cross-section of maternity care providers about structures, which are needed to support sustainable maternity care. Key informants identified that certain aspects of legislation, regulation and the funding and liability systems have entrenched barriers to the ongoing delivery of high quality maternity care and are limiting the implementation of positive change.

The current structure for regulatory change is not responsive to changes in clinical practice. Our consultations revealed situations in which simple advances in maternity care cannot be integrated without major revisions to regulations.

A commonly cited example is the lack of an effective response to the 1994 national standards established in the SOGC clinical practice guideline: *The Prevention of Early Onset Group B Streptococcal Infection in the Newborn*.⁸² Although we found agreement amongst maternity care providers that midwives should be able to prescribe this routine prophylactic antibiotic on their own responsibility, regulatory bodies report a long-standing inability to amend the drug regulation. Care providers indicate this situation has not only resulted in the need for ‘unnecessary’ medical consultations (and OHIP billings), but can also strain inter-professional relationships by creating additional demands during night time hours.

Key informants also reported that current payment models can foster a competitive approach to sharing maternity care responsibilities. OMCEP received reports on promising inter-professional maternity care models that faltered prior to implementation as a result of a lack of appropriate funding mechanisms.⁸³ There are multiple systems of

^e Managing Obstetrical Risk Efficiently (MORE^{OB}) and Advances in Labour and Risk Management (ALARM) are offered through the Society of Obstetricians and Gynaecologists of Canada. Advanced Life Support in Obstetrics (ALSO) is offered through the College of Family Physicians of Canada. All courses are inter-disciplinary risk management and patient safety programs.

payment in Ontario including salary, alternative payment plan models, capitation models, blended models and fee for service. Intersecting payment mechanisms can introduce incentives and disincentives that undermine best practice and integrated care.

“There is a need for alternate payment systems for obstetricians [for backing up primary care providers]. The fee for service system can be a real stumbling block to collaborative care. Sometimes financial issues are underlying requirements for consultation and transfer of care”

- OMCEP focus group participant, obstetrician

Provider concerns about liability were cited to OMCEP as reasons for high rates of attrition among intrapartum care providers. Concerns about joint liability, overlapping scopes and misunderstandings about the legal status of midwives and nurse practitioners as the ‘most responsible care provider’ are beginning to be addressed by national insurers but remain the frequently cited barrier to inter-professional care. Major reforms in the management and acceptance of risk are required to alleviate recruitment challenges and to support team practice.

“Most of OMCEP’s recommendations will not be achieved unless you fix the situation with insurers and their lack of support for team practice.”

-OMCEP focus group participant – Hospital Chief of Staff

“Right now, the availability of care providers, not community health needs, determines who you see. One example is well baby care. In small communities, a public health nurse does this, in slightly larger communities a [family] physician does, and in urban centres you see paediatricians doing immunizations.”

-Participant, OMCEP Focus Group for Hospital Integration Reviewers

Spontaneous Vaginal Births in Hospital

In 2003/04, 31.5% of women giving birth in Ontario went into labour and gave birth spontaneously, i.e., labour was not induced and forceps, vacuum or Caesarean section were not used. That means that 68.5% of women received some form of assistance for birth. This number does not include women who had pain relief during labour or birth, but otherwise had a physiologic labour and birth.

Interventions in the Birth Process

Ontario has significantly higher rates of medical intervention in the birthing process than other parts of Canada. For example, according to the most recent data for Ontario about 44% of women who gave birth in hospital were induced: about twice the Canadian average. Worldwide there are different opinions about the appropriate levels of delivery by Caesarean section. According to the World Health Organization, about 5 to 15% of births by Caesarean section is appropriate⁸⁴ - although there is ongoing debate about the ideal rate for Caesareans⁸⁵⁻⁸⁷ and the impact of changing demographics and the evolution of care for more complex maternal and fetal conditions. Many western countries currently have rates between 20% and 25%. Rates are increasing internationally, but there is wide variation. Australia⁸⁸ and the U.S.⁸⁵ recently reported rates of over 29% while the Netherlands and Scandinavian countries continue to report rates below 15%.⁸⁹

In 2003/04, 26% of Ontario women who gave birth in hospital had Caesarean sections, compared to 21% for Canada as a whole.⁴ Reasons for the increase in Caesarean deliveries over the last decade are not well understood but may include system factors, provider trends and changes in public expectations about childbirth care. Contributing factors often cited include increased maternal age, a decrease in the number of planned vaginal births after previous Caesarean section, rising rates of induction with first births and medico-legal pressures. Maternal request is also cited but evidence is lacking regarding the importance of this trend in Ontario. Evidence from other countries suggests that there is also much media attention to the phenomenon but the incidence is low. SOGC recommendations support Caesarean section for breech birth. A higher rate of first birth Caesarean sections always magnifies future rates of Caesarean as more repeat surgeries are performed in later pregnancies. Recent data from the United States reveals that the most common indication for Caesarean section is dystocia or prolonged labour in first pregnancies.

Use of anaesthesia during childbirth has increased markedly. Epidural anaesthesia is the most common choice women request for pain relief in labour and this is one of several types of anaesthesia that can be required. In 2003/04, 69% of women giving birth in Ontario hospitals had anaesthesia, excluding local anaesthesia.

Across the province, as well as the country, there are significant regional variations in these interventions. These issues need analysis and clarification so that women and families can be properly informed and make the most appropriate decisions.⁹⁰

Barriers to Comprehensive Maternity Care

Lack of Access to Prenatal Care and Postpartum Follow-up

In our consultations across the province, women reported a number of barriers to early and regular prenatal care including: the large number of physicians and midwives whose practices are closed, the long distances they had to travel to attend prenatal care and education classes; fragmented care when prenatal care is provided by a rotating walk-in clinic staff; and lack of timely access to prenatal screening.

Increased emphasis on options for early ultrasound and blood testing for women in the first 12 weeks of pregnancy has widened the divide between women who can access early

prenatal care and those who cannot. Priorities for reduced waiting lists in Ontario were characterized by OMCEP focus groups as overlooking maternity care.

“I tried everything, I called so many people, but I always heard the same thing: ‘you’re not in our catchment area’. How can this be? I am pregnant, I don’t have time to wait for a space to open up, I need care now.”

-Participant, OMCEP Focus Group

Obstetrical specialists report a growing number of women receiving their first maternity care services in late pregnancy as acute emergencies (e.g., maternal eclamptic seizure at 36 weeks gestation preventable by prenatal blood pressure monitoring) – an indication of inadequate prenatal care.

One manager of a family health program described that each family is allowed only one visit to the Healthy Babies, Healthy Children program. Longer term, home visits were only funded for two visits per family. Child health and Healthy Babies, Healthy Children were combined to extend the pool of resources. But there is pressure on staff resulting from shortages and lack of education. Scant community health services make it difficult to refer clients and waiting lists are common.

– OMCEP focus group participant-Administrator

Analysis of the Greater Toronto Area by the Child Health Network indicated that a significant number of neonates <1500 grams are being born in environments that are not equipped to look after their needs.⁹¹

Infants under age one have the highest frequency of visits to emergency departments. While many of these visits may be appropriate, their frequency may be a sign that a more appropriate primary care provider is unavailable. Further research is needed in this area.⁹²

Follow-up or postpartum care can help alleviate new parents’ anxiety and reduce expensive and unnecessary hospital visits. Guidelines for “Family-Centred Maternity and Newborn Care” (developed by Health Canada and the Canadian Institute of Child Health)⁹³ call for mothers and newborns to receive a minimum of six weeks postpartum care. Ontario has a wide range of programs to support new mothers and babies -- including the services provided by family physicians, midwives and nurse practitioners, public health nurses, child health programs, Aboriginal Health Access Centres, women’s health centres, Best Start and Healthy Babies Healthy Children - but women and health care professionals in our focus groups report cuts in these services in recent years. They also note the lack of integration among these programs and with other primary care and institutional services compounded by difficulties finding primary care providers taking

new patients, including newborns. Stakeholders we consulted raised concerns that lack of access to prenatal and postpartum care may be related to hospitals moving away from providing non-acute care services.

Lack of Equitable Access to Care and Culturally Sensitive Services

According to our focus groups and stakeholder consultations, current maternity care services are not meeting the needs of all recent immigrants. Women from different cultures have different needs in terms of language, translation, screening and care. Translation services, where available, may not be available 24 hours a day, creating significant barriers to effective communication during labour and birth. Immigrant women may bring with them traditions that they wish to combine with their maternity care (e.g., traditional Chinese medicine) and face difficulties in finding culturally sensitive services.

Those without health insurance may have little access to prenatal care and may present to a hospital in labour. The resources of care providers and hospitals serving non-status immigrants are overbooked and strained (OMCEP Focus Groups, 2005 – Appendix G). Although some hospitals provide clinics for the uninsured where midwives, nurses and physicians collaborate to provide care, we heard reports of denial of care even in urgent situations.

Ontario’s maternity services also face challenges in meeting the needs of aboriginal women – in either urban or rural settings. In our consultations we heard that some aboriginal women want to be able to incorporate aboriginal midwives and healers into their care or receive primary maternity care services in their own communities (OMCEP Focus Groups, 2005 – Appendix G). For the past 30 years, however, Ontario has adopted the Canadian policy of evacuating pregnant women from remote Aboriginal communities to larger centres often hundreds of kilometres away from their homes. The personal, physical, financial and family burden that all women face when evacuated for care is exacerbated for aboriginal women.⁴⁹

Some women, because of race, age, marital status, socioeconomic status and/or disability, are not able to access or receive appropriate treatment. Maternity services are often not designed to meet the more complex needs of, for example, women living in shelters or transition homes.

“I was kicked out of the last shelter because I tried to get my food [from the fridge] outside the hours. What can I do? I’m pregnant, I’m hungry and I need to eat.”

-Participant, OMCEP Focus Group

Growing Demand for Maternity Care

Ontario is already facing problems of access to maternity care; without proactive changes to our system, we anticipate serious future challenges resulting from projected increases in our population, the projected number of annual births and their geographical distribution.

According to the Ministry of Finance mid-range forecast, the population of Ontario will grow by 4 million (32.6%) to 16.43 million by July 2031. As our population grows, the number of births will also increase from the current level of about 130,000 per year to 157,000 in 2024-25. The increase in births is related to immigration projections, more women of childbearing age and slightly increasing fertility rates.

The growth will take place against the background of health service provision that is already stretched and stressed. Population increase will also be uneven across Ontario, with dramatic increases in births in some areas and status quo levels in others, as is shown by the second below chart. In some areas of the province, up to 30% more births are anticipated over a 25-year forecast. This will make planning for maternity care even more challenging in both urban and dispersed population areas.

Figure 4

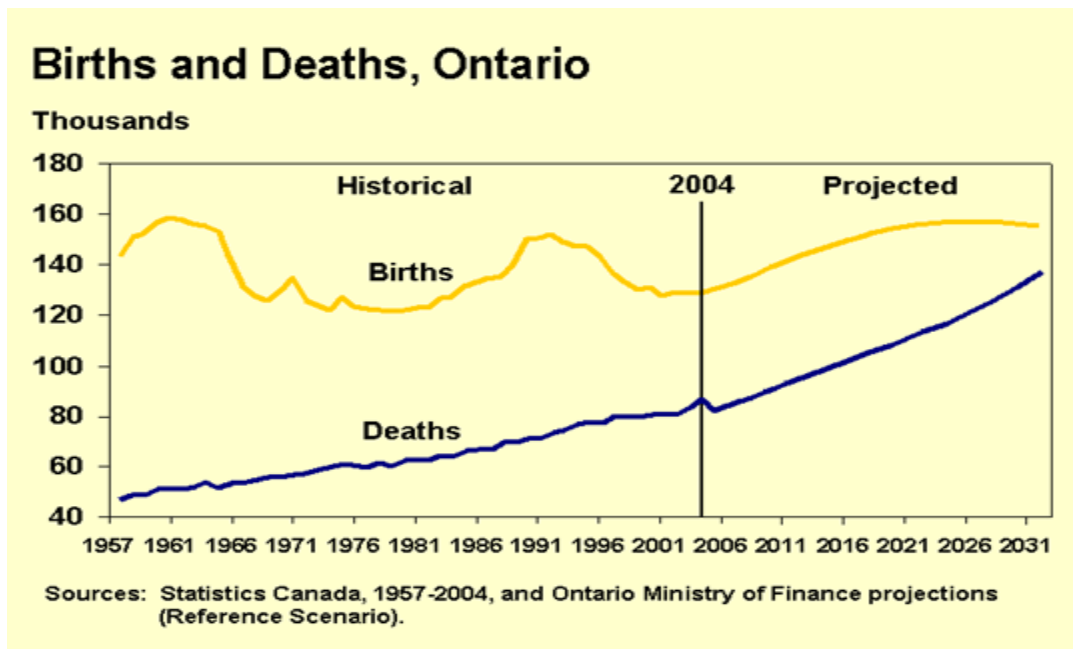
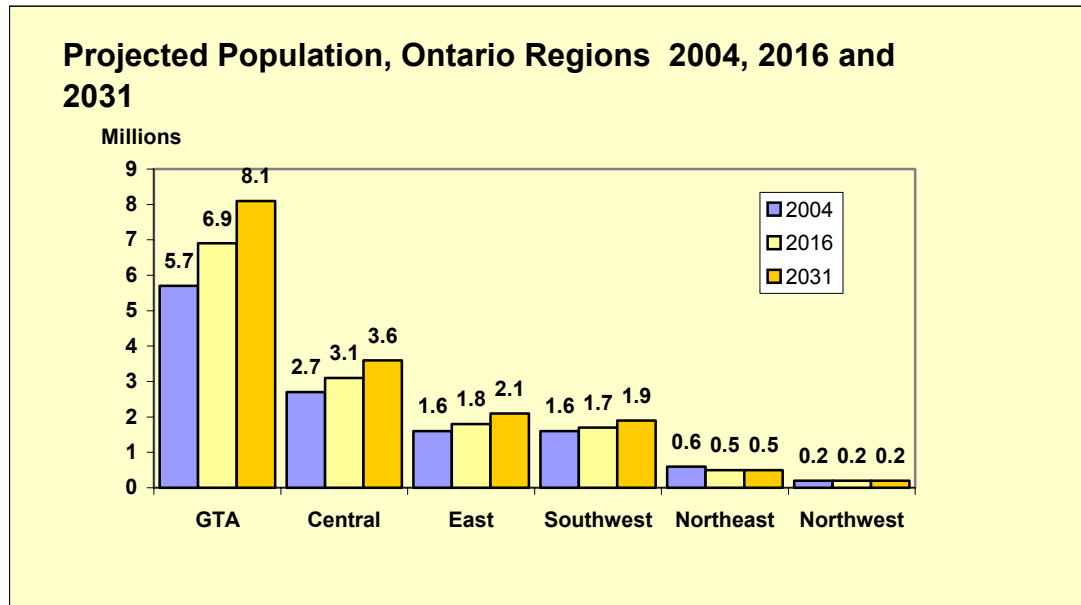


Figure 5



Adapted from Statistics Canada, 2004, and Ontario Ministry of Finance projections (Reference - midrange scenario).

Maternity Care Data

It's difficult to make good health care policy decisions without appropriate data, including timely, accurate and comprehensive maternal-newborn health information. Ontario's vital statistics are suboptimal, with regular delays in reporting; national reports on perinatal surveillance of maternal and newborn health indicators have historically excluded Ontario data due to its lack of completeness. Costing shifts to municipalities, including differential fees for birth registration, were referenced by OMCEP key respondents as contributing to families not registering some births, particularly stillbirths.

Panel members were surprised to find so little ready information and analysis relating to maternity care in the ministry. We were unable to find regularly published ministry maternity care reports on adequacy of prenatal care, comparable service delivery models, health human resources (especially for nurses), clinical outcomes, consumer satisfaction or cost-effectiveness. Most significantly, most analysis on physician health and human resource planning does not routinely identify those members of the obstetric, family practice and nursing specialties who attend births as part of their practice.

Indeed, budgets for large programs including physician payments, primary care, hospitals, public health and others were unable to extrapolate how much of their blended budgets are being spent on maternity care.

For example, although approximately 98% of Ontario births take place in hospitals, OMCEP could find no information on the distribution of hospital maternity care services until the panel surveyed hospitals last summer. Limitations regarding postal code

methodologies for tracking travel distance for women to maternity care prevented accurate analysis for most of rural Ontario. We need more systematic tracking of provincial data to improve maternity care and to ensure the right services are available where and when Ontarians need them.

A variety of government databases exist with information on health human resources, clinical outcomes, utilization of physician services, etc. What is perhaps the most extensive source of provincial data on intrapartum interventions and clinical outcomes (and also includes limited data on prenatal care) is managed by a non-governmental organization as a surveillance system. Over 90% of Ontario births are entered into the Niday database. Niday allows real time data collection, eliminating the need for hospital manual systems, and real time comparison and key indicator reports, facilitating realistic planning information. Hospitals and midwives are voluntarily participating in the Niday data collection. However, this system lacks a unique patient identifier creating challenges for linking the data with other sources. Linking some of these disparate databases to create one province-wide minimum data set for maternity care might provide the best opportunity to effectively measure the performance of several aspects of Ontario's maternity care system. An examination of current indicators for maternity care revealed some overlapping areas of data collection. For instance, perinatal data on intrapartum procedures and certain maternal and newborn outcomes for deliveries that take place in hospital can be found in the CIHI DAD as well as in the Niday database. The absence of relevant data on inter-disciplinary work teams and other important areas representing system functioning was also apparent.

While Ontario has much room to improve in this area, some ministry programs and external stakeholder groups should be commended for beginning to collect reliable, high-quality maternal and newborn health information. These initiatives include the Ontario Hospital Reports Collaborative, the Ontario Midwifery Program, the Niday Perinatal Database, Ontario's Southwest hospital region, the GTA Child Health Network, the Fetal Alert Network and others.

Several observations are offered to summarize the current state of maternity care data and indicators in Ontario:

- there are the beginnings of good sources of data for intrapartum procedures and maternal and newborn vital statistics
- the further you move away from the labour and delivery period, the less data that are available
- Public health data (Healthy Babies, Health Children) is not linked to hospital data
- more than one instrument for obtaining data on women's satisfaction with maternity care is available
- little or no routinely collected data are available on maternity care provider experiences and job satisfaction
- multiple emerging, but unfunded, options exist to collect data from hospitals on hospital services, gaps in service, maternity care providers, and practices to address challenges in providing maternity care

- although data on costs associated with physician’s services are available, good data on other costs of maternity care associated with hospitalization or services from nurse practitioners are not available, though the Ontario Case Costing Initiative may be a reasonable source of patient specific costing data for hospital stays in the future

These developing data sets represent tremendous capacity, if properly expanded and integrated together in a central repository, to support multiple ministries, the LHINs, education programs, acute care institutions, service providers and the public to make the most informed decisions about maternity care for now and in the future in Ontario

Provincial Coordination and Stewardship of Maternal Care

A System under Stress

Ontario is an excellent place to be born or to become a mother. Our infant and maternal mortality rates are among the lowest in the world.⁹⁴ Our hospital readmission rates – for both mothers and newborns – are lower than the Canadian average. This is a credit to those providing care.

However, signs are emerging that Ontario is facing a looming crisis in its ability to maintain sustainable maternity care services.

Accommodations being made by care providers now, if left unchecked, risk negatively affecting our future high quality care, the sustainability of Ontario’s health human resources, institutions and access for women to services (OMCEP Hospital Survey, 2005 – Appendix F).

Shifts in health human resources; the consolidation of birth services in fewer hospital sites; increased rates of interventions at births and reduced access to maternity services are not the result of deliberate provincial maternity care policies. Rather, they appear to be the indirect consequences of a decades-long blind spot toward the coordination of maternal-newborn health services as a whole. Ontario is fortunate that maternity care professionals, institutions, stakeholders and policy-makers across Ontario have maintained quality services amidst a fractured system and without clear policy direction and support.

Ontario is not currently making optimum use of the potential advice and support of ad hoc regional networks which, despite a lack of resources, have been convening in some regions to share concerns and solutions to maternity care issues. The care providers and women we consulted expressed frustration with the absence of a designated overarching program in the ministry tasked with improving maternal and infant health.

There is no question that Ontario faces an ageing population and compelling health care pressures from chronic disease, but by no measure does it make health care sense to neglect maternity care policy while responding to these issues. Maternity care is the ultimate long-term health care investment: it is a proactive step that contributes to Ontario’s current strategies for low birth weight, diabetes, asthma, obesity, cardiac

Access to maternity services depends on the right care at the right time in the right location. It involves timely availability of a range of health care services including: pre-pregnancy counselling, early and regular prenatal care, education, low to high-risk intrapartum services and postpartum maternal and newborn care.

disease, and cancer. By raising the prominence of maternity care, the province should expect improved long-term health outcomes, reduced chronic disease and more efficient management of downstream health expenditures.

Many key informants across Canada impressed on us the importance of provincial leadership and resources to support a ministry-led maternal-newborn care program as part of a well-functioning system, as opposed to other solely regional or local approaches to coordination. Strategies in other provinces typically involve a framework that situates maternity care as a key part of provincial primary care policy, with a coordination mandate that empowers the province to conduct maternal-newborn health campaigns and to maintain cohesion among provincial regions and relevant programs delivering services across the maternal-newborn care continuum.

Informed perspectives from many provinces that have undertaken regionalization initiatives of their own informed our view that without a provincial maternity care framework, the potential introduction of 14 LHIN planning and funding processes for maternity care will risk further deterioration of an already fragile system. LHINs would benefit from working collaboratively within a provincial strategy.

Looking forward, we hope that Ontario can learn from effective provincial stewardship models from other provinces and are grateful that we could use these models as the groundwork for our recommendations.

A VISION FOR MATERNITY CARE IN ONTARIO

PREAMBLE

OMCEP believes that quality maternity care requires widespread access for healthy women to local primary (low-risk) care and public health services from the prenatal stage through to postpartum care, plus a clear integrated infrastructure that ensures access to specialist advanced care when women are identified to have such needs.

Panel discussions and consultations revealed commonality and diversity in philosophies of care for pregnancy and birth, both among and between care provider groups and others we consulted. OMCEP's Vision and Principles received broad endorsement. Although stakeholders referred to them as so uncontentious as to be "motherhood and apple pie", the panel believes they are a strong basis on which to build the maternity care system, although we know that not all care providers will agree with all aspects. It would be unfair to either stereotype any of the provider groups or to avoid noting the potential importance of diverse views and philosophies in discussions of how to structure maternity care; the meaning and implications of the "normalcy" of birth and the "risks" of birth are central to debates about how to interpret evidence for best practice, how to plan services and how to improve inter professional relationships.

These debates are not unique to Ontario: they are national and international and have been well documented in the medical and social science literature.^{84,95,96} OMCEP expects them to continue. Clinical practice and health policy is not simply based on scientific evidence but reflects philosophies, attitudes and cultures. Provincial stewardship and professional leadership is needed to provide ongoing forums for debate and dialogue across the professions, with policy makers and with the public. Openly engaging these issues is a vital part of the process of collaboration and development of best practice.

Based on our experience providing maternity care and on our consultations with women, health professionals and others across the province, the Ontario Maternal Care Expert Panel proposes the following vision and principles to guide maternity care in Ontario.

OMCEP Vision Statement:

Every woman in Ontario has access to high quality, woman and family-centred maternity care as close to home as possible.

GUIDING PRINCIPLES FOR MATERNITY CARE IN ONTARIO

Woman and Family-Centred Care Principles

Care across the Continuum of Maternity and Newborn Care:

Comprehensive maternity care will be available to all women, newborns and their families across the continuum of maternity care services: from pre-pregnancy planning and prenatal care, through labour and birth, to postpartum maternal and infant care and breastfeeding support.

Optimal clinical care and health promotion and education are available across the continuum of care. Each woman will receive the information and education she needs, to promote informed decisions, the healthiest possible pregnancy, a safe and fulfilling childbirth and early parenting experience. Care includes breastfeeding support and postpartum care, for the woman her newborn and her family.

Equitable Access to Care as Close to Home as Possible:

The maternity care system supports women to give birth in their communities, whenever possible. Local birth services are designed to support the best health outcomes for women and newborns, provide family-centred care and maintain the family unit and strengthen the community. Each community should develop a local maternity care plan that will ensure that, as many elements of maternity care are available locally as possible. At a minimum, prenatal and postpartum care should be available in each community, and low-risk labour and birthing services should be available as close to home as possible.

Innovative and collaborative models of care are in place to help communities make the most of their available resources and maintain maternity services, even in communities with a low volume of births, such as rural and remote areas. Given the diverse geography and populations of Ontario, equitable access does not mean care options will always be the same in all regions. The guiding principle for system planning is access to primary prenatal, intrapartum and postpartum maternal and newborn care as close to home as possible.

If the size of the community, lack of providers or facilities limits maternity services and care has to be provided at a distance from the mother's home, maternity care services should cover the cost of transportation (to and from the setting for birth) and accommodation for the woman and at least one other family member.

Pregnancy and Birth as a Normal Physiological Process:

The process of pregnancy and childbirth will be viewed as a normal physiological process for most women and an important life event for all women and families. The majority of women have low-risk pregnancies and the maternity care system will be primarily organized around providing services appropriate to each woman's needs. Care systems advocate and promote best practices to support normal birth, appropriate use of intervention and excellent outcomes. Inter-disciplinary Centres of Excellence for Normal Birth, established both in hospitals and in the community, will lead research and education which supports best practice for physiologic birth.

Regional Coordination of Services and Access to High-Risk Care:

Provincial and regional maternity care plans include coordinated access to high-risk care in each region, as close to home as is possible and meeting the transportation needs of the family. Quality maternity care is based on primary care in communities and regional centralization of high-risk care, involving a critical mass of specialized staff. Early recognition, intervention and transportation to such specialized facilities should be available to all women requiring complex care.

Outreach, including links between low and high volume centres, Telehealth and other electronic links to consultation and treatment are part of regional access to service, education and planning. Regional centres are not only referral centres but are regional resources for designated community hospitals and other maternity services, thus fostering co-ordination, integration, accountability and improved levels of care.

Empowerment and Participation of Women:

Maternity care in Ontario will have as its primary focus the women and families using the services. Woman-centred care places the woman at the ‘heart’ of the efforts of all her health care providers and as an integral member of the care team. Her needs and choices will determine the focus for the planning and delivery of her individual maternity care. This philosophy of care is distinct from an approach to service provision organized primarily around the needs of the provider, the hospital or the health care system.

Women’s empowerment in personal and systemic decision-making around maternity care will be an integral part of Ontario’s maternity care model and will lead to an increase in accountability. A women-centred maternity care system can only exist with the active participation of women in the planning, delivery, monitoring and evaluation of maternity care services at the local, regional and national level. Women who have used the maternity care system will participate along side providers to be represented in all major policy, planning and evaluation initiatives of that system.

Family-Centred Care:

Care is recognized as a relationship, which involves a partnership between care providers, women and their families. Care is provided according to *National Guidelines for Family-Centred Maternity and Newborn Care*: “a complex, multidimensional, dynamic process of providing safe, skilled and individualized care. It responds to the physical, emotional and psychosocial needs of the woman and her family. In family-centred maternity and newborn care, pregnancy and birth are considered normal, healthy life events. As well, family-centred maternity and newborn care recognizes the significance of family support, participation and choice. In effect, it reflects an attitude rather than a protocol.”

Continuity of Care – including continuity of “carer”, of philosophy, of relationship:

The hallmarks of continuity of care are a familiar relationship and/or philosophy of care between each woman and the team of care providers involved throughout the course of pregnancy, birth and postpartum care. Continuity of “carer” occurs when one provider or a small team known to the woman is responsible for the woman’s care throughout pregnancy and childbirth. Continuity can also be provided by teams

who share the same philosophy of care and effectively share information about the woman's care plan. Each maternity service will inform women about their approach to continuity of care.

Informed Choice:

Maternity care providers will respect the autonomy of women receiving maternity care, consistent with clinical ethics and provincial legislation. Women will make choices in maternity care based on information about the best available evidence and their needs, values and preferences. Choice entails the right to select the provider, the nature of her maternity care and childbirth services, and the location where she gives birth, informed by best practice clinical guidelines whenever available. Informed choice means that women will have full and timely access to education based on the available evidence, including risks, benefits and alternatives. Information should include community standards, the care provider's recommendations (if any), and what is known and not known related to both safety and satisfaction in order for each woman to be in the best position to make decisions about her maternity care.

Choice of Birthplace:

Choice of birthplace includes access to maternity care in local communities, as close to home as possible. Choice of birthplace is guided by informed choice about potential benefits, limitations, risks and alternatives. Maternity units in hospital provide women choice through a philosophy of care, processes and procedures designed to offer care in a personable setting. Birth centres offer choice of birthplace in some communities. A percentage of women choose a home birth and Ontario's maternity care system respects and responds to that choice and supports the care providers who attend home births.

Quality Care to Diverse and Vulnerable Populations:

Ontario's maternity care system will be responsive to the needs of all women, including diverse and vulnerable populations of women who may face additional barriers to care. In Ontario, care to diverse populations includes aboriginal women and their families, diverse racial and ethno-cultural communities and francophone communities. Maternity services will also address potential barriers to care including: age; body size; disabilities; fear of partner abuse; language barriers; marital status; mental health issues; poverty or low socio-economic status; rural and remote status; sexual orientation; substance use or other challenges.

All women will receive socially and culturally appropriate maternity care, without fear of discrimination. Maternity care providers (including aboriginal midwives and francophone providers) will receive education about systemic marginalization of vulnerable communities and be sensitive to diverse health care needs. Maternity services will strive to be open, accessible and inclusive.

Maternity care planning, from the local to the provincial level will take into account the needs of diverse and vulnerable communities and principles of social justice.

Principles of Service Provision

Valuing Maternity Care Providers:

All those involved in the health care and education systems in Ontario will promote maternity care as a respected and viable career goal for health care professionals. Each maternity care provider group will be valued and each in turn will value the other. Retention of quality care providers can only occur when the health care system acknowledges the responsibilities of maternity care and supports providers with the education, skill development, reimbursement and incentives needed for the length of their careers. To protect maternity care in small communities, and rural and remote areas, the provincial model will undertake whatever additional education, skill development, remuneration and incentives are necessary to support providers working under these unique circumstances.

Collaboration – Respectful, Seamless, Inter-professional:

Collaboration is a prerequisite for high quality maternity care and relies on mutual respect, trust and support among all health care providers and mechanisms to resolve issues between team members. Care providers will learn about and understand each other's scopes of practice; support each other to work fully within their scopes and value each other's roles and contributions. Through multiple models of maternity care, including multi-professional and inter-professional models, effective relationships are fostered between care providers and also with the women and families they serve. Each maternity care service has mechanisms to promote respectful and effective collaboration and to resolve problems if they arise. The principles of collaboration are reflected in service provision and policy-making.

Provider Preparation, Competence and Confidence:

All maternity care providers should receive high quality preparatory and continuing academic and clinical education, and be offered advanced skills development and mentoring throughout their careers. With the rapidly changing research information, continuing education is a key part of inter-disciplinary learning. With this education, providers can develop the competence and confidence needed to offer women and children the highest quality of care. Ongoing inter-professional education opportunities foster a common understanding of emerging care practices.

A provincial model of maternity care will utilize a health and human resources planning process to ensure a sufficient number of the following: openings in schools of medicine, nursing and midwifery to meet the Province's need for new providers, continuing education for ongoing providers, and advanced skills placements to providers in key areas of maternity care. Academic and clinical learning centres will develop, promote and teach inter-professional models of education and collaboration.

Sustainable Services:

Maternity services are designed to both meet the needs of women and their families and to balance the importance of job satisfaction, respectful work environments and reasonable lifestyle for retaining care providers and maintaining a sustainable service for the community. Each community and region is involved in planning for models of care, recruitment and retention that promote long-term access and sustainability.

Principles of Provincial Stewardship and Coordination

Provincial Coordination of Services:

The health and well-being of all pregnant women, their children and families, is best protected by an effective provincial coordination of services which supports regional networks of services and equitable implementation at the local level.

Provincial stewardship and coordination is based on a population health perspective; services are planned and delivered based on an accurate assessment of regional and population needs, with a goal of equity of services across all communities.

Coordination will include a permanent and fully-funded central planning mechanism for maternity care, with active participation by women users of services, representatives from all provider groups, as well as those coordinating any legislation, policy, regulations and liability protection issues for maternity care providers.

Maternity Care as a Part of Primary Care

Ontario will align its maternity care systems with its primary health care initiatives in keeping with the World Health Organization Ljubljana Charter on Reforming Health Care.^f Since most women have normal uncomplicated pregnancies, their maternity care should be aligned with their other primary health care needs and options for care by the most appropriate primary health care providers including family physicians, midwives, nurse practitioners and obstetricians (offering primary care). Strong linkages should be developed between health promotion initiatives for women and pregnancy planning and early prenatal care. Women and their children should be supported well into the postpartum period and linkages made to parenting services, to Early Years' programs for young children, and to primary health care and mental health services for new mothers.

Alignment of System with Determinants of Health through Other Ministries:

Maternity care must exist within a framework of general health and social well being for all women. Achievement of optimal health involves a balance of physical, mental, environmental and social contributors. The Province will co-ordinate with other ministries on an inter-sectoral approach to the promotion of health through

^f In 1996, the World Health Organization passed the "Ljubljana Charter on Reforming Health Care". In that document WHO affirmed the following fundamental principles for health care. Health care systems should be:

1. driven by values of human dignity, equity, solidarity, and professional ethics;
2. targeted on protecting and promoting health;
3. centred on people, allowing citizens to influence health services and take responsibility for their own health;
4. focused on quality, including cost effectiveness;
5. based on sustainable finances, to allow universal coverage and equitable access; and, oriented toward primary health care

policy that addresses the determinants of health as outlined by Health Canada^g.

Continuous Evaluation and Improvement:

All stakeholders participate in the planning, monitoring, evaluation and continuous improvement of maternity services. Individual providers and maternity care organizations protect the health of women and children by instituting, monitoring and improving standards of maternal and neonatal care. Provincial stewardships supports individuals and organizations with the funding, data collection, risk management and research necessary to maintain Ontario's standards as among the highest in the world.

Financial Responsibility and Accountability:

Cost effectiveness is an important guiding principle for Ontario's model of maternity care, provided it is always considered within the context of quality of care principles. The goal is to ensure the allocated budget is spent in a coordinated, integrated and effective manner, responsive to the needs of women their families and their children

^g The factors which can affect an individual's health, or that of a whole community or population, are called 'determinants of health'. Health Canada lists 12 main determinants of health. (OMCEP has made some slight alterations to the last two determinants):

- income and social status;
- social support networks;
- education and literacy;
- employment/working conditions;
- social environments;
- physical environment
- personal health practices and coping skills;
- healthy child development;
- biologic and genetic endowment
- health services
- gender
- culture

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