



# **Making Midwifery Services Accessible to People of Low SES: A Qualitative Descriptive Study of the Barriers Faced by Midwives in Ontario**

*Rendre les services des sages-femmes accessibles aux personnes de statut socioéconomique faible : étude descriptive qualitative des obstacles affrontés par les sages-femmes en Ontario*

---

Elizabeth K. Darling, RM, PhD, Tonya MacDonald, RM, MSc, Lisa Nussey, RM, BSc, Beth Murray-Davis RM, PhD, and Meredith Vanstone, PhD

---

## ABSTRACT

Midwifery care is associated with health benefits for disadvantaged groups but continues to be accessed less frequently in Ontario by people who are of lower socio-economic status (SES). We conducted a qualitative descriptive study investigating the work midwives do to make midwifery care accessible to people of low SES and explored the barriers they encounter in doing this work. We interviewed 13 Ontario midwives who serve people of low SES in a wide range of clinical settings. Participants faced multiple challenges in their work to make midwifery care more accessible. They described barriers that they had encountered which pertained to the nature of the work itself, to professional and organizational factors, and to systemic factors. Midwives engaged in this work are deeply committed to it and take on extra unpaid work. The barriers they face threaten the sustainability of their work, and as a result, many participants identified a high risk of burnout. Our findings provide new insight into ways in which gaps in the curriculum of undergraduate midwifery education, lack of opportunities for mentorship, and debate within the midwifery profession about who is suitable for midwifery care serve as barriers to midwives taking on a greater role in providing care to people of low SES and particularly to those who struggle to access primary maternity care services. Systemic changes are needed to overcome these barriers and to expand the work of making midwifery care more accessible while ensuring its sustainability.

## KEYWORDS

midwifery; health services accessibility; social class; health care quality, access, and evaluation; maternal health services; barriers

*This article has been peer reviewed.*

## RÉSUMÉ

Les soins prodigués par les sages-femmes sont associés avec des bienfaits pour la santé des groupes désavantagés, mais les personnes de statut socioéconomique faible continuent d'y avoir accès moins souvent en Ontario. Nous avons réalisé une étude descriptive qualitative qui s'est penchée sur le travail effectué par les sages-femmes afin de rendre leurs services accessibles à ces gens et a examiné les obstacles auxquelles elles font face à cet égard. Nous avons soumis à une entrevue 13 sages-femmes ontariennes qui desservent des personnes de statut socioéconomique faible dans un large éventail de milieux cliniques. Les participantes ont relevé de multiples défis pour rendre les soins des sages-femmes plus accessibles. Elles ont décrit les obstacles auxquels elles se sont heurtées du fait de la nature du travail en soi, de facteurs professionnels et organisationnels et de facteurs systémiques. Les sages-femmes qui se livrent à cette activité sont profondément engagées envers celle-ci et font du travail supplémentaire non rémunéré. Les obstacles essuyés menaçant la viabilité de leur travail, de nombreuses participantes ont fait état d'un risque élevé d'épuisement professionnel. Nos constatations jettent une nouvelle lumière sur les manières dont les lacunes du programme de baccalauréat en pratique sage-femme, l'absence de possibilités de mentorat et les débats au sein de la profession sur les individus aptes à pratiquer celle-ci empêchent les sages-femmes de jouer un plus grand rôle dans la prestation de soins aux personnes de statut socioéconomique faible, en particulier à celles qui éprouvent de la difficulté à accéder à des services de soins de maternité primaires. Des changements systémiques sont nécessaires pour surmonter ces obstacles et travailler davantage à rendre les soins des sages-femmes plus accessibles tout en assurant leur viabilité.

## MOTS-CLÉS

pratique sage-femme; accessibilité des services de santé; classe sociale; soins de santé : qualité, accès et évaluation; services de santé maternelle; obstacles

*Cet article a été évalué par un comité de lecture.*

---

## INTRODUCTION

Across Canada, access to maternity care, and to midwifery care in particular, is uneven. Public funding of midwifery services aims to reduce financial barriers to midwifery care,<sup>1</sup> but even in Canadian jurisdictions where midwifery services are available and publically funded, people of low socio-economic status (SES) remain less likely to obtain midwifery care.<sup>2</sup> Canadian research shows that midwifery-led continuity-of-care models are perceived to offer a good fit by people of low SES who access them<sup>3</sup> and points to potential benefits in terms of clinical outcomes, including a decrease in the likelihood of newborns being born preterm or small for gestational age.<sup>4,5</sup> However, people of low SES remain less aware of midwifery and face barriers that make them less likely to seek out midwifery care.<sup>6</sup>

In several Canadian jurisdictions, regulatory and funding mechanisms have been implemented to support more equitable access to midwifery care.<sup>7</sup> While previous research has sought to understand policy factors that might support equity in access to midwifery care in Canada,<sup>7</sup> there has been limited research on midwives' experiences of engaging in work to make their care more accessible. As part of a larger program of mixed-methods research on access to midwifery care for people of low SES,<sup>2</sup> we asked, "How do midwives work to make midwifery care accessible to people of low SES?" [In another article, we have described the ways in which Ontario midwives work to make midwifery services accessible to people of low SES.]<sup>8</sup> The objective of this article is to describe the barriers that Ontario midwives face in trying to make their services more accessible to people of low SES, focusing on barriers that are specific to midwifery care.

### **Study Context**

Midwives in Ontario must be registered members of their regulatory body, the College of Midwives of Ontario, which protects the public by ensuring that midwives meet the high expectations of the profession's principles and standards of practice.<sup>9</sup> The standards of midwifery practice have evolved since midwifery was regulated in Ontario in 1994; midwives in the province continue to work in a client-centred, relational model of care that

spans pregnancy, birth, and the postpartum period and is founded on philosophical tenets that include informed choice, choice of birthplace, and continuity of care.<sup>9</sup>

Midwifery services in Ontario are fully funded for Ontario residents by the Ontario Ministry of Health even if they do not have provincial health insurance. Midwives are paid for a bundle of services (referred to as a course of care) that includes care provided throughout pregnancy, labour, and birth, and care for up to 6 weeks post partum for both the client and newborn. Funding flows through midwifery practice groups and is limited by annual practice group caseload allocations. Compensation for each completed course of care includes remuneration for the billing midwife and a fixed fee to cover operational expenses. Special funding is also available to midwifery practice groups through what are called caseload variables, which are intended to compensate for administrative and clinical work not included in regular courses of care. Our study was conducted just as new funding arrangements to support expanded models of midwifery care were being implemented in Ontario; our participants were working under the original funding arrangements that continue to be the basis for remuneration for most Ontario midwives.

### **Theoretical Framework**

We approached this research from a constructivist philosophical perspective, which acknowledges the subjective nature of human interpretations of reality. We understand SES to be a complex construct that combines educational attainment, income, employment, and occupation to measure social inequality.<sup>10</sup> Hence, we understand low SES to include low educational attainment; low income; precarious employment, underemployment, or unemployment; and low occupational prestige. We did not define low SES for our participants, and we acknowledge that there are a variety of ways low SES can be measured and understood. We also recognize the concept of intersectionality, which points to the relationships and interactions between SES and other aspects of social identity—such as race, gender, and sexual orientation—that influence relative social advantage.<sup>11</sup> Our research engaged midwives who were working with people of low SES,

---

but often it was other aspects of the clients' social identities or life circumstances that were the focal point of midwives' outreach work. We acknowledge the importance of considering the interactions between other aspects of social identity and SES when working to improve access to care, as well as avoiding the conflation of low SES with other reasons for marginalization, such as substance use or incarceration.

## **METHODS**

### ***Design***

This qualitative research study was part of a larger mixed-methods research program. In this article, we report the findings of a qualitative descriptive study that explored the barriers midwives in Ontario face in providing care to people of low SES. We chose a qualitative descriptive approach as a naturalistic and low-inference approach to descriptive inquiry,<sup>2</sup> aiming to provide a "comprehensive summary of an event in the everyday terms of those events."<sup>12</sup>

### ***Participants, Setting, and Recruitment***

We used purposive and snowball sampling to recruit currently practicing Ontario midwives who were known for their efforts to increase access to midwifery care or whose midwifery work was in a socio-economic context of interest. All participants were working in some capacity with people of low SES. We sought participants from diverse settings, including urban, semiurban, rural, and remote communities across Ontario. Participants were contacted by email or in person. Final sample size was determined by thematic saturation of the data.

### ***Data Collection***

One author, who is a registered midwife and a master's degree student, used a semistructured interview guide to conduct individual interviews (either in person or by telephone) after obtaining consent. Throughout the data collection phase, the interview questions were adapted in light of emerging new insights and as part of the iterative analytic process. Interviews were transcribed verbatim.

### ***Analysis***

The interview transcripts were coded and

managed with NVivo version 12 qualitative data analysis software (QSR International, Boston, MA). The transcripts were coded by two authors who are registered midwives with graduate-level training in qualitative research methods. We used thematic analysis to identify and describe patterns of meaning across the transcribed interviews. The iterative process of thematic analysis was guided by Braun and Clarke's six phases of analysis: [1] becoming familiar with the data, [2] coding the data systematically, [3] grouping codes under potential themes, [4] validating themes in relation to coded data and the entire data set, [5] defining and naming themes, and [6] producing the final report with selected extracts. Three members of the research team met regularly throughout the analysis to review the initial coding, discuss grouping of codes into themes, ensure that the reported results remained close to the findings, and select quotations to illustrate the findings.

### ***Criteria for Rigour***

To achieve rigour in our research, we used the following criteria, based on Whittemore and colleagues' work on validity in qualitative research: credibility, authenticity, criticality, and integrity. These criteria are appropriate for the qualitative descriptive approach we used.<sup>13</sup> To ensure credibility and authenticity, we worked to remain true to the data that were collected and to accurately represent the perspectives of our participants when analyzing and reporting the data. Our research team included four registered midwife researchers and one nonclinician qualitative researcher. We paid attention to our own influence during the process of conducting and analyzing the interviews, and we reviewed our themes and quotations carefully as a team to ensure that we represented the multivocality of participants' voices. We encouraged participants to tell their own stories and to identify barriers based on their experiences rather than on the pre-existing ideas of the research team. We used an iterative research design to ensure criticality and integrity by performing repeated recursive checks of our interpretations as they were formulated and by interrogating discrepant opinions and conflicting interpretations.

## Ethics

We obtained approval from the Hamilton Integrated Research Ethics Board for this study. We have endeavored to avoid identifying the participants that are quoted by masking identifying contexts while still remaining close to the participants' words. All participants were provided a summary of our main findings to review prior to publication, and all participants were given the opportunity to review their own quotations.

## RESULTS

We interviewed 13 midwives between January 2018 and June 2018. Interviews lasted approximately 50 to 60 minutes. Participants worked in settings across Ontario, ranging from a remote solo midwifery practice to a large, urban practice of 19 midwives. They served clients from a variety of backgrounds, including young people, uninsured clients, newcomer clients, Indigenous clients, people without housing, people who use drugs, people with mental illness, people with HIV, people who engage in sex work, people recently incarcerated, people involved with child protection services, Amish and Mennonite populations, and rural and remote people living in poverty. Some participants worked in midwifery practices whose population consisted predominantly or entirely of clients of low SES, while others served more economically diverse populations. How representative a participants' client population was of the demographics of their catchment area varied.

The barriers that participants encountered in their work to increase access to care fell into three areas: [1] the demanding nature of the work, [2] professional and organizational relationships, and [3] systemic factors. Table 1 summarizes the themes that emerged within each of these areas.

### **The Demanding Nature of the Work Time and Energy**

Although there was diversity in the characteristics of the clientele served by participants, almost all participants talked about the heavy demands associated with caring for clients of low SES. These demands, which included both clinical and nonclinical work, were reported as a key challenge

in increasing clients' access to midwifery care. Participants described needing to devote time for extra care during visits, supplemental home or out-of-office visits, and additional in-person assessments. They also described the effort needed to liaise with colleagues, other health care providers, and community service providers, and to advocate for their clients. They talked about investing effort in developing expertise, establishing a reputation, and gaining credibility with clientele, community, and other health care providers. Participants also stated that the extra work needed to deliver the accessible, high-quality midwifery care they were providing was not reflected in their income.

*"I realized partway when I was starting to get this going that I absolutely could not work full-time as a midwife and get this done. I couldn't go to the meetings I needed to go to. I couldn't do the writing...I needed support from organizations like [an inner-city health organization], which is like the outreach nurse. Well, when I first approached them, they were like, well, a midwife could never do this. So I need to then engage in a conversation with them to show them how it can work. Well, that takes a lot of time. It takes me meetings, it takes me writing, it takes me pulling resources together for people."*

### **Emotional Labour**

While almost all participants described a deep sense of fulfillment and joy in doing this work, many participants indicated that working to make midwifery care more accessible can be emotionally demanding. The personal toll of the work was described by almost all participants.

*"You feel like you're screaming in thin air, like nothing happens. You can't get help. You can't get support. Yeah, so it gets to be heavy, you know? So I would often come home and feel quite heavy and sad, and I can't talk to anybody, because I'm carrying everybody's secrets."*

Participants described being discouraged by the seemingly intractable nature of the difficulties their clients faced, worrying about the well-being of their clients, feeling frustrated with the inflexibility of the

**Table 1.** Key Findings

Category	Themes
The demanding nature of the work	<ul style="list-style-type: none"><li>• Time and energy</li><li>• Emotional labour</li></ul>
Professional and organizational relationships	<ul style="list-style-type: none"><li>• Midwifery practice group culture</li><li>• Hospital and interprofessional relationships</li></ul>
Systemic factors	<ul style="list-style-type: none"><li>• Midwifery education</li><li>• Regulation: the midwifery scope of practice and model of care</li><li>• Funding arrangements</li></ul>

various systems that they and their clients worked in and with, and feeling alienated and isolated from many of their colleagues who were doing more conventional midwifery work. The combination of heavy time demands and the emotional burden of the work led participants to identify a notable risk of burnout. Despite the heavy burdens, several participants expressed having a sense of duty for the work they do, regardless of how insufficient that work might seem at times.

*“So, no matter how hard we work sometimes, these complex issues are more difficult to address than we are capable of and the system here is capable of. And it’s so much deeper than what organizations are available, what service providers are willing. I mean, it’s generations and generations of trauma and marginalization and discrimination, and that doesn’t get undone through the course of one pregnancy [by] a competent care provider. So, you know, we do our best because we’re motivated morally and we’re motivated ethically, and we’re obligated because this is the population we’ve chosen to serve.”*

**Professional and Organizational Relationships**  
**Midwifery Practice Group Culture**

An oft-cited barrier to increasing access to care for people of low SES was midwives themselves.

The small number of participants working in practice groups with a shared vision for increasing access described this shared commitment as vital to their success. However, the remaining participants described how the culture of their midwifery practice group and their intraprofessional relationships impeded their ability to provide care to people of low SES. They described their disappointment and frustration with tensions within their practice group and the broader midwifery community. These tensions arose out of disagreements about who is suitable for midwifery care, about the extra work created by serving marginalized populations, about attitudes toward the clients themselves, and about the lack of opportunities to focus on certain populations.

Although many people of low SES fit the historical categorization of “healthy” or “low risk,” the complex social circumstances of the populations served by several of the participants in our study created clinical complexity that stretched that boundary. Some participants spoke of their work not being seen as midwifery work by midwife colleagues but instead being held with contention and opposition, even while other health care providers in their community saw them to be working in positive collaborative partnerships. They described being actively challenged by, and living with, ongoing criticism from colleagues while working toward an expanded knowledge base and gaining expertise in caring for persons with more-complex needs.



---

*“Why are we saying [that] if you have more than a certain amount of knowledge, an expertise, that you’re not a midwife and that’s a bad thing?”*

The contrasting views on who is suitable for midwifery care were evident even among our participants. One participant explained the approach of limiting who is accepted for midwifery care in her community.

*“Midwifery serves sort of healthy, normal childbearing women, whatever their complex needs are. If there’s a massive dimension of medical complexity, really our scope says it’s better for those people to be cared [for] by a specialist, i.e. , a physician or an obstetrician. So I don’t dispute that here, because there are plenty of healthy ‘normal’ childbearing people who should have access to midwifery care.”*

Some participants also spoke about the ways in which other midwives in their practice groups held the stigmatizing attitudes that they were actively working to overcome, and how this has hindered efforts to develop more far-reaching midwifery programs to increase access to care.

*“It really wasn’t a possibility for them to cover me because of their own sort of opinions and perspectives about my client population. So, like, some of the ideas in my practice about my client population are, like, why will we buy bus tickets for people if they smoke cigarettes, because they could afford bus tickets if they didn’t smoke? Or if you do all of those visits, then, like, you play right into that inability for them to make it to appointments, and if you just didn’t do that, then they would come because they would have to come. So there’s a real lack of understanding about people just not coming.”*

The hierarchy within practice groups was noted as a barrier to working with people of low SES, particularly for more junior midwives. They spoke about how practice group partners’ lack of transparency about practice group funding limited their knowledge about how they might be able

to better serve the community’s needs. Some participants perceived an unwillingness to involve less-senior or nonpartner midwives in decision making and described having “their hands tied” because they did not have a voice in their practice group and thus couldn’t influence its direction or priorities.

*“That’s where I would love to put my energy as a midwife in that community, and I can’t do it if the practice doesn’t support it.... So it’s like a big wall to create these things when you’re, like, ‘the community needs it.’”*

A common refrain from participants was their sense of burdening midwifery colleagues because of the work they do. They noted that the pressures of building and sustaining a midwifery practice group as a business already leaves midwives feeling overworked, and this can lead to unwillingness to take on extra work. The lack of a willing, capable, and devoted pool of midwives to share the additional administrative, outreach, and advocacy work needed to serve certain populations creates a vulnerability in projects that are often tied to the contextual interests and ambitions of individual or small groups of midwives. Several participants warned that the midwifery profession must build capacity and take responsibility in order to foster sustainability.

*“You have to have people who are doing the work because they want to be doing the work. And for it to be sustainable, even though it’s different [in] the remote north... than the small south, it’s the same issue of you need a team that wants to share that work. Otherwise, you have people who go out and do some advocacy, go out and do some outreach, go out and do some trust building, and if anything comes up in their own lives that interrupts their capacity to do that work and that person disappears, if there isn’t someone that’s been working with them, then that kind of work kind of dissolves and then has to be reinitiated over again.”*

### **Hospital and Interprofessional Relationships**

Relationships with hospitals and other health care providers significantly affect midwives’

## Midwives' inclusion and even leadership in the hospital system were necessary to increase access to care for an extremely high-risk population.

ability to provide care to low SES populations with additional needs. When midwives were able to liaise and collaborate with other health care providers, they were usually better able to increase access to midwifery care or other services, and they were better able to meet their clients' particular needs. In contrast, barriers to midwifery care for people of low SES were created in settings where interprofessional relationships were described as ineffective. Several participants who worked with a large number of uninsured clients described the strain placed on their interprofessional relations. They came to be known as the bringers of unpaid work to their obstetric and anaesthesia consultants. One participant viewed hospital hierarchy as a rigid barrier to midwives' providing care to persons of low SES. She spoke about how infiltrating the infrastructure and culture, which didn't recognize her work or her potential role, placed an additional burden on her already taxed schedule and energy levels. At the same time, she recognized that midwives' inclusion and even leadership in the hospital system were necessary to increase access to care for an extremely high-risk population.

Interprofessional relationships, as well as the potential for collaborative arrangements to meet the needs of clients with more-complex needs, were affected by the mix of care providers available in each local context. In some settings, this led midwives to carefully negotiate their caseloads with physician colleagues (so as not to compromise interprofessional relationships) and consequently to limit their involvement in caring for some people of low SES.

*"In our level two, I would say that there's a group of physicians that they're trying*

*to increase their care load, so they're looking to have more women stay with them and even come to them for pregnancy, which we don't want to be battling either, because I want to support physicians if they want to [be] doing that very difficult call work."*

Midwives indicated that some family physicians did not refer clients who might not know about midwifery services but who could benefit from the model. This unwillingness to refer clients was attributed in some instances to physicians' lack of awareness of midwifery services and scope of practice that leads to the incorrect labelling of clients as "high risk" and thus not suitable for midwifery care. In other instances, the unwillingness to refer was attributed to issues of territoriality and a need for physicians to preserve their own income.

### **Systemic Factors Midwifery Education**

All participants expressed the need for a specialized skill set to be able to provide care to some populations of clients of low SES. The specific knowledge and skills needed varied, depending on the characteristics of the clients, and might relate to social and clinical needs. Several participants referred to the absence of this specialized content in the curriculum of the Ontario Midwifery Education Program (MEP) and identified the lack of education and training as a barrier to midwives working with people of low SES.

*"The midwifery students come into midwifery not fully understanding what they're getting into, I think....just that education piece that you will be providing care to...so many different people with so*



---

*many different backgrounds.”*

Participants suggested that the MEP should foster an ethos of midwifery care that includes outreach to a more economically diverse clientele. They suggested that greater attention within the curriculum to the importance of supporting this kind of midwifery work would help cultivate interest, build engagement, and generate an ongoing commitment within the profession to build or at least support this specialized expertise.

*“And I just hope, like, even if not all midwives wanted to do it, if it was part of the philosophy of the MEP to talk about how you serve a population that doesn’t have vehicles, then my midwifery partners would be aware of that. So even if they didn’t want to do that work themselves, there would be, like, a place in their brain where they were like, ‘oh, okay, that’s a way you can do midwifery.’ It’s a possibility.”*

A lack of focus on how to provide accessible care in the MEP means that midwives who are actively engaged in working with people living in poverty, people with substance use disorder, or people with serious mental health conditions, have engaged in self-study or bring expertise from previous experiences to better meet the needs of their clients. Midwives with this type of expertise remain a minority in the profession. Two participants stated that this results in a void in mentorship, which is a further barrier for midwives interested in doing this kind of work.

*“I feel like I always had support to do that kind of work if I wanted to do that kind of work but that I didn’t necessarily have the mentorship to do that kind of work. And so I would like to see that kind of mentorship become more widely available.”*

### **Regulation: The Midwifery Scope of Practice and Model of Care**

Participants spoke about how the regulatory framework for midwifery in Ontario and the model of care it supports create both opportunities and barriers for midwives to increase access to midwifery care for people of low SES. Participants viewed

the model of midwifery care as supporting access to midwifery care for people of low SES<sup>14</sup> but also heard that elements of the model created barriers to working with some populations. Participants explained that each of the historical tenets (informed choice, choice of birthplace, and continuity of care) could be problematic for work with marginalized populations, creating tension between best serving the needs of clients and strictly adhering to the standards of the College of Midwives of Ontario and, in some instances, creating barriers to improving access to care.

*“But I would say you need to be flexible and see what the client needs are, because we get very use[d] to providing care in one way, but sometimes clients will require us to do things differently.”*

One participant explained that adapting informed-choice discussions to individual needs means sometimes sacrificing a narrow continuity-of-carer approach in order to have appropriate information provided by any midwife in the practice who can speak the client’s primary language. Several participants identified the privilege inherent in promoting home birth as optimal and its effect on the choice of birthplace by people of low SES, especially those who are suspicious of others coming into their homes or who are homeless, precariously housed, or living in crowded conditions.

Midwives noted that in addition to being constrained by the model, they were also limited by the narrow scope of midwifery practice. They noted that the complexity of care required to meet the needs of some people of low SES—for example, in regard to particular medical conditions or substance use—was manageable in the context of good interprofessional relationships, but that efficiencies and improvements to care could be achieved with, for example, access to prescribed birth control and treatment for sexually transmitted infections.

### **Funding Arrangements**

Our interviews revealed that the funding arrangements for midwifery services in Ontario create both opportunities and barriers for midwives seeking to care for people of low SES. While some elements of the funding arrangements for midwifery

---

services in Ontario supported participants' making their services accessible to people of low SES (for example, funding for all Ontario residents supports midwifery care for clients who are uninsured, and caseload variables compensate midwives who spend exceptional amounts of time travelling to rural clients), participants emphasized the limitations of current funding arrangements.

Many persons of the populations served by participants are more likely to present to care later in pregnancy. However, the combination of course-of-care funding and fixed annual caseloads incentivizes midwifery practice groups to book clients into care early (to ensure that they are able to fill their allocated caseload), thus preventing them from accepting clients who call later in their pregnancy. Furthermore, one participant described how the funding arrangements create competition between midwifery practice groups for clients and discourage collaborative and innovative approaches that might increase clients' access to care (e.g., a shared birth room at one midwifery practice group made available to clients of all local practice groups). Many participants discussed the constraints of the course-of-care model of funding and described feeling "boxed in" by a one-size-fits-all package that doesn't actually work for all clients. One participant said, "Like, it's the interface of what's going on in people's lives and the way care is structured that's somehow not working."

Midwives largely described the model of care as highly suited to their meeting the diverse needs of many clients of low SES in ways that could not easily be achieved by other care providers. At the same time, the funding model constrained midwives' ability to parse care in different ways or adapt it to the needs of individual clients.

*"It takes time to go [visit a client] many times to be let in one of those several times that you attempt to go. And so those things are challenging in terms of how health care is funded. We're not funded to do a lower volume, because it takes more time to provide that care."*

Primarily, course-of-care funding does not support episodic care (i.e., prenatal or postpartum care that doesn't constitute a complete course of

care), which is essential to care provision in a harm reduction context or work with transient or difficult-to-reach populations. Participants also described being unable to create robust collaborative models with other care providers, either because this is seen as double billing or because there is no mechanism to pay the midwife for work that doesn't constitute a full course of care in a collaborative model. Caseload variables in the existing funding arrangements acknowledge additional work outside of standard courses of care. However, as one participant pointed out, this mechanism is not sufficient to fund all the work a midwife is doing and is not intended to fund alternate models of care. Participants said that the lack of funding for the extra work demanded by a mission to serve those who struggle to access conventional models of care makes it difficult to garner the intraprofessional support needed to make the work sustainable.

One participant suggested that there may be untapped opportunities within the flexibility of the current funding arrangements to use operational fees, for example, to midwives to provide a small amount of episodic care that would not otherwise be billable. However, participants also felt that unwillingness at the midwifery practice group level to consider creative solutions that break away from a "conventional midwifery practice" was a barrier to midwives' providing care to persons of low SES.

Finally, during the time our interviews were conducted, the Ontario Ministry of Health announced alternative funding arrangements to help midwives begin to work in new service delivery models. While participants welcomed the idea of alternative and less-constrained funding models, they also indicated that the already heavy demands on midwives' time present a further barrier to individuals or practice groups doing this work, given the time required to conceptualize, concretize, and present formal proposals for consideration.

## **DISCUSSION**

We identified seven themes, within three categories, related to the barriers that Ontario midwives face in trying to make midwifery care more accessible to people of low SES and particularly to those who face additional barriers to accessing health care. Our findings provide new

## Systemic changes are needed to expand the work of making midwifery care more accessible.

insight into ways in which gaps in the curriculum of undergraduate midwifery education, lack of opportunities for mentorship, and debate within the midwifery profession about who is suitable for midwifery care are barriers to midwives' taking on a greater role in providing care to people of low SES, particularly those who struggle to access primary maternity care services.

Several of the themes align with previous Canadian midwifery research. "Extra work" was identified as a theme in previous research exploring the experiences of Ontario midwives who provide care to people who are without provincial health insurance.<sup>15</sup> Researchers from British Columbia have also noted that midwives involved in caring for potentially disadvantaged populations in low-resource (i.e., rural) settings take on an additional burden of work beyond what is compensated by course-of-care billing, calling for alternative funding arrangements to make this work viable.<sup>16</sup> The importance of funding arrangements that support midwives in providing flexible services to diverse populations was also a key theme in research examining factors that affect equity in access to midwifery care in five Canadian jurisdictions.<sup>7</sup> Funding Ontario midwives to provide care to people who are without provincial health insurance supports work to increase access to care, but previous researchers have also found that this funding can be a potential source of interprofessional tension.<sup>15,17</sup> More broadly, interprofessional relationships have been highlighted in previous research as a key factor influencing equitable access to midwifery care in Canada.<sup>7</sup> Finally, our finding that midwifery regulations can limit midwives' work to improve access to midwifery care echoes previous findings that both the scope of practice (i.e., normal pregnancy and birth) and

elements of the model of care (e.g., choice of birthplace) influence equitable access to care.<sup>7</sup>

Our research also reveals some themes that are not present in previous Canadian midwifery research on this issue. Although Hanson et al. identified "risk designation" as a factor influencing equitable access to midwifery care, their discussion of risk focused on scope of practice.<sup>7</sup> Our findings reveal debate within the midwifery profession about how social and clinical "risk" should determine eligibility for midwifery care. Several of our participants articulated a need for a shift in perception regarding the suitability of midwives' providing care to people who struggle to access primary maternity care services and for a moral imperative for midwives to do this work. Their position aligns with Sandall's proposition that "Every woman needs a midwife, and some women need a doctor too."<sup>18</sup> Our findings indicate that as the midwifery profession continues to grow and serve an increasing proportion of the Canadian population, there is a need for ongoing dialogue within the profession to ensure that the potential contributions of midwifery are maximized by nurturing a culture that supports midwifery work to improve access to care. While previous research has recognized the importance of both regulation and funding as systemic factors influencing access to midwifery care, our findings also highlight the importance of midwifery education. Participants who felt that their efforts to improve access to midwifery care were hampered by their midwife colleagues were both critical of gaps in midwifery education and hopeful that attention to these gaps could provide a way to promote the knowledge, skills, and attitudes that would support a change of culture within the profession.

Our study was strengthened by the variety

---

of contexts in which the midwife participants worked and by the ethnic and economic diversity of the populations they served. While some of our findings are particular to Ontario, the alignment of our findings with those of research from other Canadian jurisdictions suggests that our findings will likely have some relevance in other parts of Canada as well. A single interviewer who had experience as a midwife working with people of low SES facilitated the establishment of a good rapport with interviewees and an iterative approach that allowed us to check our interpretations as they evolved. Context is essential to qualitative research, and our study was completed before new funding arrangements to support expanded models of midwifery care were fully implemented in Ontario and just prior to the implementation of new professional standards for midwifery care in Ontario.<sup>9</sup> It is possible that the barriers identified by our participants might shift and change as new models and standards are implemented. Our team is undertaking research to understand more about the impact of the new midwifery funding arrangements in Ontario, but given that the funding offers some increased flexibility in remuneration to midwives, we anticipate that it may positively affect midwives' ability to improve equitable access to care.

The demanding nature of the work involved in providing access to midwifery care for people of low SES is unlikely to change. However, our findings imply that there are several ways in which systemic changes might help alleviate the burden of the work and support improvements in both the intra- and interprofessional relationships needed to facilitate the work.

First, funding arrangements that appropriately compensate midwives for episodic care and for the extra time involved in caring for populations with extra needs are essential to eliminating current disincentives to take on this work and to ensuring that the work is sustainable. Developing funding arrangements that would alleviate current interprofessional tensions regarding care for people who are without health insurance could also be helpful.

Second, our findings indicate a need for flexibility in the midwifery model of care and its philosophical underpinnings to ensure the appropriateness of

midwifery services aiming to meet the needs of those who struggle to access primary maternity care. This flexibility can likely be achieved while also sustaining access to the existing model of continuity-of-care midwifery for most midwifery clients. Midwifery regulators should consider applying an "equity lens" to evaluate proposed changes in midwifery regulations.

Finally, enhancements to the curricula of midwifery education programs have the potential to provide foundational knowledge and skills, shape attitudes, and foster the ability to develop successful interpersonal relationships so that the work of improving access to midwifery care is taken up more broadly within the profession. Support from the professional association for the development or expansion of communities of practice and opportunities for mentorship for midwives engaged in this work could facilitate further learning.

## **CONCLUSION**

The efforts of Ontario midwives to make midwifery care accessible to people who live in rural and remote regions or to those who are living in poverty, using substances, precariously housed, homeless, or face other barriers to care are largely ad hoc and often depend on the good will and interests of the midwives involved. Further, the sustainability of midwives' work to increase access is often threatened by the factors described in this article. Midwives who are engaged in this work are deeply committed to it and emphasize the value of midwifery's personalized, mobile approach to care. At the same time, midwives face multiple barriers to doing the work and thus feel a high risk of burnout. Systemic changes are needed to overcome these barriers and to expand the work of making midwifery care more accessible while ensuring its sustainability.

## REFERENCES

1. Van Wagner V. Why legislation? Using regulation to strengthen midwifery. In: Benoit C, Bourgeault IL, Davis-Floyd R, editors. *Reconceiving midwifery*. Montreal and Kingston: McGill-Queen's University Press; 2004. p. 71-90.
2. Darling EK, Murray-Davis B, Ahmed RJ, Vanstone M. Access to Ontario midwifery care by neighbourhood-level material deprivation quintile [2006-2017]: a retrospective cohort study. *Can J Midwifery Res Pract*. 2020;19(3):8-23.
3. Heaman M, Sword W, Elliott L, Moffatt M, Helewa ME, Morris H, et al. Perceptions of barriers, facilitators and motivators related to use of prenatal care: a qualitative descriptive study of inner-city women in Winnipeg, Canada. *SAGE Open Med* [Internet]. 2015;3:1-9. Available from: [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4822530/pdf/10.1177\\_2050312115621314.pdf](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4822530/pdf/10.1177_2050312115621314.pdf)
4. McRae DN, Muhajarine N, Janssen PA. Improving birth outcomes for women who are substance using or have mental illness: a Canadian cohort study comparing antenatal midwifery and physician models of care for women of low socioeconomic position. *BMC Pregnancy Childbirth*. 2019;19(1):1-11.
5. McRae DN, Janssen PA, Vedam S, Mayhew M, Mpofo D, Teucher U, et al. Reduced prevalence of small-for-gestational-age and preterm birth for women of low socioeconomic position: a population-based cohort study comparing antenatal midwifery and physician models of care. *BMJ Open* [Internet]. 2018;8(10):e022220. Available from: <http://bmjopen.bmj.com/content/early/by/section>
6. Darling EK, Grenier L, Nussey L, Murray-Davis B, Hutton EK, Vanstone M. Access to midwifery care for people of low socio-economic status: a qualitative descriptive study. *BMC Pregnancy Childbirth*. 2019;19(1):416.
7. Hanson L, Mpofo D, Hopkins L. Toward equity in access to midwifery: a scan of five Canadian provinces. *Can J Midwifery Res Pract*. 2013;12(2):8-18.
8. Nussey L, MacDonald T, Murray-Davis B, Vanstone M, Darling EK. Community as client - the work of midwives to increase access to midwifery care: A qualitative descriptive study. *Can J Midwifery Res Pract*. 2020;19(3):24-39.
9. College of Midwives of Ontario. Standards of practice [Internet]. Toronto: The College; 2020. Available from: <https://www.cmo.on.ca/resources/standards-of-practice/>
10. Guidelines for detection, management and prevention of hyperbilirubinemia in term and late preterm newborn infants [35 or more weeks' gestation]-summary. *Paediatr Child Health*. 2007 May;12(5):401-7.
11. Hankivsky O, Reid C, Cormier R, Varcoe C, Clark N, Benoit C, et al. Exploring the promises of intersectionality for advancing women's health research. *Int J Equity Health*. 2010;9:1-15.
12. Sandelowski M. Whatever happened to qualitative description? *Res Nurs Health*. 2000;23(4):334-40.
13. Whittemore R, Chase S, Mandle C. Validity in qualitative research. *Qual Health Res*. 2001;11(4):522-37.
14. Nussey L, MacDonald T, Murray-Davis B, Vanstone M, Darling EK. Community as client: a qualitative descriptive study of the work of midwives to increase access to midwifery care. *Can J Midwifery Res Pract*. 2020;19(3):24-39
15. Bennett N, Burton N. Midwives responding to the needs of uninsured clients: old order and new immigrant women in midwifery care. *Can J Midwifery Res Pract*. 2012;11(3):8-17.
16. Barclay L, Kornelsen J. The closure of rural and remote maternity services: where are the midwives? *Midwifery* [Internet]. 2015;38:9-11. Available from: <http://dx.doi.org/10.1016/j.midw.2016.03.007>
17. Burton N, Ariss R. The critical social voice of midwifery: midwives in Ontario. *Can J Midwifery Res Pract*. 2009;8(1):7-22.
18. Sandall J. Every woman needs a midwife, and some women need a doctor too. *Birth Issues Perinat Care*. 2012;39(4):323-6.

## AUTHOR BIOGRAPHIES

**Elizabeth K. Darling, Tonya McDonald, Lisa Nussey, and Beth Murray-Davis** are affiliated with the McMaster Midwifery Research Centre, McMaster University, Hamilton, Ontario.

**Meredith Vanstone** is affiliated with the Department of Family Medicine, the Centre for Health Economics and Policy Analysis, and the McMaster Faculty of Health Sciences Education Research, Innovation & Theory (MERIT) program, McMaster University, Hamilton, Ontario.