
ARTICLE

Toward Equity in Access to Midwifery in Saskatchewan: Key Informants' Perspectives

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ABSTRACT

In this article, we report on the second phase of our exploratory research into issues related to equity in access to midwifery in Saskatchewan. This phase of the research project aimed to explore equity in access to midwifery as understood and experienced by key stakeholders involved in the early stages of midwifery implementation in Saskatchewan. A total of 19 interviews were conducted with participants from Saskatchewan Health, the Midwifery Transitional Council, and Saskatoon's Regional Midwifery Operations Committee, as well as practitioners, primary health care managers, directors from select regional health authorities, and Saskatchewan midwives. Additionally, all available midwifery policy documents and relevant Primary Health Care and Health Human Resource documents complemented the qualitative analysis.

Initial thematic analysis led to five policy recommendations: (1) develop a provincial definition of "priority population" for midwifery clients, (2) establish a midwifery health human resource plan, (3) identify provincial midwifery research priorities, (4) facilitate growth in interprofessional relationships, and (5) develop a provincial "road map" for implementation. A secondary analysis of participants' responses revealed concern over the poor public education about midwifery services and lack of provincial government prioritization, as well as varied perceptions of the concept of "equity."

We conclude that although general commitments to equity in midwifery service and access are enshrined in Saskatchewan's health care policies and midwifery regulations, insider perspectives suggest that significant yet modifiable barriers to equity in access to care currently exist.

KEYWORDS

midwifery, midwives, health services accessibility, equity, delivery of health care

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ARTICLE

Vers l'équité en matière d'accès à la pratique sage-femme en Saskatchewan : Points de vue de partenaires clés

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RÉSUMÉ :

Dans le cadre du présent article, nous nous penchons sur la deuxième phase de notre recherche exploratoire traitant des questions liées à l'équité en matière d'accès à la pratique sage-femme en Saskatchewan. Cette phase du projet de recherche cherchait à explorer l'équité pour ce qui est de l'accès à la pratique sage-femme, telle que comprise et vécue par des personnes clés participant aux premiers stades de la mise en œuvre de la pratique sage-femme en Saskatchewan. Au total, nous avons mené 19 entrevues auprès de participants issus de Saskatchewan Health, du Midwifery Transitional Council et du Regional Midwifery Operations Committee de Saskatoon, ainsi qu'auprès de praticiens, d'administrateurs de services de soins primaires, de directeurs issus d'autorités sanitaires régionales triées sur le volet et de sages-femmes de la Saskatchewan. De plus, tous les documents de politique disponibles au sujet de la pratique sage-femme et tous les documents pertinents traitant des soins de santé primaires et des ressources humaines en santé ont été utilisés pour compléter l'analyse qualitative.

L'analyse thématique initiale a mené à la formulation de cinq recommandations de politique : (1) élaborer une définition provinciale pour ce qui est du concept de « population prioritaire » en ce qui concerne les clientes de la pratique sage-femme; (2) établir un plan en ce qui concerne les ressources humaines en pratique sage-femme; (3) identifier les priorités provinciales en matière de recherche dans le domaine de la pratique sage-femme; (4) faciliter le développement des relations interprofessionnelles; et (5) élaborer une « feuille de route » provinciale pour ce qui est de la mise en œuvre. Une analyse secondaire des réponses des participants a révélé l'existence de préoccupations quant à la piètre qualité des efforts de sensibilisation du public à l'égard des services de pratique sage-femme et quant à l'absence de priorisation de la part du gouvernement; cette analyse a également mis au jour diverses perceptions quant au concept d'« équité ».

Nous en venons à la conclusion que, malgré le fait que des engagements généraux envers l'équité en matière de pratique sage-femme (et en ce qui concerne l'accès aux services de celle-ci) soient inscrits dans les politiques de soins de santé et la réglementation de la pratique sage-femme en Saskatchewan, les points de vue recueillis auprès de personnes clés semblent indiquer qu'il existe actuellement des obstacles considérables, quoique modifiables, à l'équité en matière d'accès aux soins.

MOTS CLÉS

pratique sage-femme, sages-femmes, accessibilité des services de santé, équité, prestation des soins de santé

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INTRODUCTION

Based on noted concerns about the influence of organizational and policy contexts on the accessibility of midwifery care throughout Canada, and with the intent of informing efforts to equitably roll out midwifery in Saskatchewan, a team of researchers and midwives recently carried out a two-phase study funded by the Saskatchewan Health Research Foundation. The study was guided by one overarching question: How can midwifery care be implemented in an equitable and accessible way in Saskatchewan? In an earlier article in this journal, we reported our findings on the first phase of that research, which examined equity policies and practices across five provinces.¹

In 2013, we completed the second phase of our research, which sought to determine how organizational, policy, and regulatory contexts influence access to midwifery care for diverse groups of women in Saskatchewan, based on the perspectives and experiences of those involved in its implementation. Our research was predicated on provincial health care policies and midwifery regulations that outline commitments to equity in access to health care, particularly for “priority populations. A research assistant interviewed 19 members of Saskatchewan Health, the Midwifery Transitional Council, and Saskatoon’s Regional Midwifery Operations Committee, as well as select medical practitioners, primary health care managers, directors from regional health authorities with midwifery care, and Saskatchewan midwives. She also gathered all available midwifery policy documents and relevant Primary Health Care and Health Human Resource documents and subjected the data to a qualitative thematic analysis, making use of NVivo software (QSR International, Burlington, MA). Throughout the analysis, team meetings helped to determine which emerging themes had the greatest potential for modifying contextual and policy issues at the provincial or health region level. The five themes that were identified in the preliminary analysis were documented, and all stakeholders were invited to comment, although only a few did so. Our Report on Phase II gave a snapshot of the current state of midwifery care in health regions of Saskatchewan and offered recommendations regarding a number of salient policy issues as well as promising directions for future midwifery development.

RESEARCH BACKGROUND AND METHODS

In the first phase of this exploratory research, we conducted an environmental scan consisting of policy and

regulatory document analyses and interviews. Two midwife-researchers conducted key interviews with stakeholders from British Columbia, Manitoba, Ontario, Northwest Territories, and Nova Scotia. By focusing on legislative, organizational, and practice issues in these provinces, we aimed to: (1) identify models, policies, and strategies that can influence access to midwifery care for diverse women and (2) discern and examine best practices for establishing equitable and accessible midwifery care.

Overall, we found considerable provincial variation in practices and policies in support of equity in midwifery implementation. From a Canadian perspective, six organizational and policy factors — differently interpreted — most significantly influence equitable access to the full scope of midwifery care: (1) flexibility in the funding model, (2) the state of interprofessional relationships, (3) human health resource issues, (4) risk designations that interact with and affect access to midwifery by priority populations, (5) geographic dispersal, and (6) midwives’ approach to community integration and outreach. (A full description of the phase-one results can be found in “*Toward Equity in Access to Midwifery: A Scan of Five Canadian Provinces*,” published in the *Canadian Journal of Midwifery Research and Practice* (12)2. Many observations from the first pan-Canadian research resonated with the experiences of team members and informed how we approached the second phase and how we crafted some of its recommendations.

In developing the research for phase two, the team sought to keep the research contextually relevant and useful for Saskatchewan policy-makers and midwives. Thus, we focused on understanding the organizational, policy, and regulatory context of midwifery implementation in Saskatchewan and limited the scope of the study to the three Regional Health Authorities that have practicing midwives. Policy-makers, managers, primary care practitioners, and midwives have been somewhat differently situated vis-à-vis the strategies and policies that are intended to facilitate the rollout of midwifery, and those different positions allow for many vantage points from which to assess if, how, and how well the equitable rollout of midwifery is being carried out. Correspondingly, the study’s main objectives were to understand how the current contexts, perspectives, and experiences of midwifery implementation are influencing actual and potential access to midwifery care for diverse groups of women in Saskatchewan. Secondly, we sought to identify information and research needs for the ongoing development of the equitable implementation and expansion of midwifery care specific to Saskatchewan.

Given the scant research and limited documentation on midwifery in Saskatchewan to date, we chose a qualitative and exploratory approach, prioritizing the understandings and experiences of key stakeholders involved in the early stages of midwifery implementation. Hence, the primary source of data for the study was key informant interviews.

To prepare for the interviews, the research assistant conducted a thorough review of the relevant literature and policy documents and developed a conceptual framework. This enabled the team to consider the functions of different agencies, department committees, and structures associated with midwifery implementation in the province, and provided a policy context in which to frame the final questions, instruments, and data analysis of the study. We invited interviewees on the basis of: (1) their level of experience and history in implementing midwifery, (2) their position of influence in implementation, and (3) our desire to capture a variety of stakeholder perspectives. The 19 participants included midwives who were currently practicing in Saskatchewan health regions and who were approached through the Saskatchewan College of Midwives. For select interviews, we invited provincial health region directors and managers working with midwifery programs, provincial policy-makers, and those involved with midwifery regulation, including members of the Transitional Council and the Saskatchewan College of Midwives. Based on convenience sampling, we also interviewed primary care practitioners who were identified and invited by members of the Saskatoon Health Region Midwifery Operations Committee. Six of the interviewees were from the Saskatoon Health Region.

All interviews were recorded and transcribed. Interviewees were offered the opportunity to review their transcripts, although most did not. The transcriptions and relevant policy data were then coded with NVivo software. For our first thematic analysis, we chose to focus on policies deemed most relevant and modifiable by our Midwifery Advisory Committee, which consisted of managers and midwives in the Saskatoon Health Region, members of the faculty of the University of Saskatchewan, and a researcher from the Prairie Women's Health Centre of Excellence. (Several of the committee members were also former midwifery clients.) Those themes and related policy recommendations formed the basis of our Phase II Report, which was released at an invitational meeting in Saskatoon celebrating the International Day of the Midwife 2013.²

For the secondary analysis, a doctoral student researcher not involved in the initial analysis recoded the interviews

for the purpose of understanding the more personal meanings participants ascribed to their experiences of the implementation of midwifery. The results of that analysis are presented here for the first time.

RESULTS

In addition to thematically analyzing the documentary and interview data, we constructed a narrative "snapshot" of midwifery in the province in 2013 (presented below). Following that summary, we present the results of the initial thematic analysis, which highlighted five areas of recommended policy, educational, and organizational changes in implementation strategies. This section ends with highlights of the secondary analysis.

A "Snapshot" of Saskatchewan Midwifery in 2013

Saskatchewan passed the *Midwifery Act* in 1999, but the act was not implemented until 2008, making Saskatchewan one of the last provinces to recognize and fund midwifery services.³ As of May 2013, there were 12 registered midwives employed in Saskatchewan: six in the Saskatoon Health Region; two in the Cypress Health Region; and four in the Regina Qu'Appelle Health Region (RQHR), including one in Fort Qu'Appelle's All Nations' Healing Hospital, which is affiliated with the RQHR. Of Saskatchewan's practicing midwives, two were trained in Canada whereas the remaining ten were trained internationally.

All midwives in Saskatchewan are salaried employees of Regional Health Authorities (RHAs), although provincial midwifery legislation permits private practices in which midwives are responsible for all overhead costs and are paid by the women in their care.⁴ Decisions concerning midwifery funding and salaries are made at the provincial level, by Saskatchewan's Primary Health Services Branch.⁵ However, because RHAs negotiate independently with the province for midwifery services, implementation and availability of services has been uneven between regions.

Midwifery is regulated through the Saskatchewan College of Midwives (SCM), which the *Midwifery Act* established in February 2007.⁶ In practice, however, the Transitional Council (created to help establish the SCM) remains the governing body for midwifery regulation. All practicing midwives in Saskatchewan must be registered with the SCM.

Saskatchewan does not have a midwifery education program, but incentives exist to encourage new graduates to migrate to the province. For example, the Ministry of Health provides a bursary program for hard-to-recruit

professionals, including midwives. The program offers students registered in midwifery programs \$7,000 per year in exchange for a year of midwifery employment in Saskatchewan for up to a maximum of two years. Although applicants can indicate a preference for employment in urban, rural, or northern settings, preference is given to applicants who are willing to work in Saskatoon or Regina.⁷ (There is no explicit rationale for this preference.)

Saskatchewan Health offers a similar \$7,000 “return-in-service” bursary for internationally trained midwives who complete the Multi-jurisdictional Midwifery Bridging Program, Ontario’s International Midwifery Pre-registration Program, or the Prior Learning and Experience Assessment (although participants noted that there are ongoing irregularities and inconsistencies in accessibility to the bridging program). In addition, under the Graduate Retention Program, Saskatchewan midwives who have earned undergraduate degrees out of province are eligible for a tuition refund of up to \$20,000.⁸

Originally, the recognition of inequities among women contributed to the decision to require Saskatchewan midwives to maintain caseloads consisting of 40%–50% “priority populations,” as recommended in the Manitoba model that Saskatchewan adopted.⁹ Yet the actual proportion of clients drawn from particular priority populations remains unknown due to variations in reporting and in defining target populations. The Midwifery Program Clinical Activity Report produced by the Saskatoon Health Region (SHR) offers a glimpse into the number and type of services used by midwifery clients in one year, although again the data are not disaggregated in a way that would permit a determination of which groups within the designated priority populations are or are not accessing care. Aggregated data from April 1, 2010, to March 31, 2011, indicate that 268 midwifery clients—6% of whom were from priority populations—were provided with service in the SHR. The split between planned home births and hospital births was fairly even, but there was a slight preference (53%) for home births. Although interviewees also reported many gaps and irregularities in the early management of information on wait-lists, the Midwifery Program Clinical Activity Report indicates that 26 women were wait-listed for midwifery care in the SHR from April to December of 2010. During the same eight-month period in 2011, 80 women were wait-listed, a 308% increase over the previous year. Statistics from the RQHR from Oct. 1, 2011, to December 31, 2011, indicate that Regina’s midwives successfully incorporated approximately 15% of women

from priority populations into their caseloads. During this period, 85% of the women delivered in hospital and 15% gave birth at home.¹⁰

Primary Thematic Analysis

Provincially Defining “Priority Populations”

Key to enacting the principle of equity within primary health care services in Saskatchewan is the provision of care to “priority populations.”¹¹ Similarly, The Integration of Midwifery into the Saskatoon Health Region: Consultation and Collaboration, a 2007 document by the Saskatoon Health Region, encouraged midwives to carry diverse caseloads, specifically ensuring opportunities for priority populations to access care.¹² Operationally, however, interviewees defined priority populations pertaining to maternal health in diverse ways; the definitions included adolescents, newcomers to Canada, Aboriginal Peoples, women affected by poverty, women having limited or no access to perinatal care (e.g., having no family doctor), women who are socially isolated (including those in rural populations), women who are socially at risk, and women who want to give birth at home. During our research, one SHR document that included all but the last category of women surfaced, but (based on our interviews) it had not been widely disseminated. Although the SHR and RQHR reports on priority populations in their caseloads, we found no consistent or shared definition of priority populations at the provincial primary health care level or among providers and managers in RHAs, making comparisons and measurements somewhat unreliable. An additional challenge was an apparent divide between what policy-makers (at both the provincial and RHA levels) and medical practitioners identified as priority populations that were suitable candidates for midwifery care; that is, because priority populations include women living with adverse conditions (e.g., substance abuse, food insecurity, or inadequate access to health care), some interviewees expressed concern that these clients, by definition, would have a high obstetric risk and be ineligible for midwifery care.

Establishing a Midwifery Health Human Resource Plan

During the course of research, interviewees unanimously expressed concern over the lack of midwives in Saskatchewan and the absence of any systematic plan for increasing their numbers in relation to the current demand. This fundamental fact seems to drive a number of other issues. For one, midwifery services are inequitably distributed in the province; some RHAs have either no

midwives or insufficient midwives on staff to support choice in birthplace in congruence with the Canadian midwifery model of practice. In addition, midwifery in Saskatchewan continues to be of low visibility and to be poorly understood by managers, other health care providers, and the public. It is perhaps exemplary that there is no explicit mention of midwives in the provincial Health Human Resources Plan¹³ and only cursory mention in the primary health care framework.¹¹

Participants noted that education programs are non-existent in the province and that in spite of some incentive to study outside of the province through bursaries, the net effect is one of loss of the potential for the growth of a “homegrown” cadre of midwifery professionals.² In addition, preference in regard to bursaries is given to those returning to Regina and Saskatoon. The program documents give no explicit rationale for the preference, nor are reasons provided to applicants, but it is reasonable to speculate that the current practice might affect rural and northern regions differentially.

The implementation of midwifery in some regions has been inhibited by resistance to midwifery and by interprofessional tension.

Interviewees stressed the need for reliable and continued support of “bridging” programs to facilitate the integration of internationally trained midwives already in the province or those willing to relocate here. Some participants suggested that Saskatchewan rapidly increase the number of second attendants in RHAs in order to provide midwives greater support for practicing the full scope of midwifery while the number of Saskatchewan midwives increases to fulfill the service need. The establishment of prior learning assessments for Saskatchewan-based second attendants, doulas, and others with related experience was felt to be a mechanism for facilitating their potential entry into the midwifery profession.

Participants also emphasized that RHAs implementing midwifery services for the first time should be advised to recruit a minimum of two or three midwives to provide the full scope of midwifery practice, in order to ensure that all Saskatchewan women enjoy choice of birthplace equitably.

Currently the RHAs establish their implementation plans autonomously, without such guidelines. At least one region was unable to offer home birth for a time because of insufficient staffing. Furthermore, the study indicated the urgent need to consult with the appropriate authorities and to ascertain needs and strategies for the establishment of midwifery in Aboriginal communities.

Facilitating Growth in Interprofessional Relationships

Although many midwife respondents had positive experiences while working with other health care practitioners, including those in the SHR, the implementation of midwifery in some regions has been inhibited by resistance to midwifery and by interprofessional tension. Some felt that philosophical differences caused tension with other professionals, particularly (but not exclusively) in regard to home birth. At times, the midwives’ scope of practice was underestimated and the midwifery model of care subject to misinformed assumptions. Midwifery “productivity” levels were questioned in some instances, and roles and responsibilities during in-hospital births were ill defined.

Frankly, a caseload of 40 clients per year is very low productivity ... I mean, 40 women a year? It's trivial. I know they spend huge amounts of time per woman, and I'm just telling you that frankly I'm not sure what they find to talk about. (Participant 6)

Tension between nurses and midwives when attending in-hospital births seemed largely attributable to shifting and unclear roles and responsibilities. Although they willingly invested considerable effort, midwives felt that they shouldered a disproportionate responsibility for professional relationship building.

There is a fear by primary care providers that midwives are just a duplicate level of care. (Participant 7)

Developing a Provincial “Road Map” for Implementation

What is the overall plan for midwifery services in Saskatchewan? What's the long-term view here, are there any targets that the provincial government is setting, and with those targets, will there be funding to support or continue to fund midwifery services as a fundamental service in Saskatchewan? (Participant 17)

Despite many shortfalls, many interviewees expressed relief that midwifery was “finally” funded and regulated in the province, and they viewed its implementation as a major achievement. Nevertheless, implementation to date is reported as being rather quotidian, heavily relying on the knowledge and good will of senior managers and midwives rather than following a defined and directed provincial roll-out strategy. Many interviewees thus emphasized the need for provincial guidelines or a “road map” to guide RHAs in implementation and to set common protocols and standards for ensuring equity in access to full-scope midwifery care across the province.

I think that the government needs to have a better vision for where they want to see midwifery in two, three, five years from now, with a real, a real, ability and tangible ability to address the education of midwives and the HR capacity. (Participant 14)

Another salient issue that was raised regards plans concerning rural midwifery, an issue on which key informants expressed a wide range of opinions. Some interviewees felt that midwifery would be a perfect solution for the problem of reaching geographically isolated women, particularly those in rural areas where prenatal care was especially difficult to access. Midwifery was also viewed as an apt means of returning birth to communities in the North. However, some interviewees thought that, given current midwifery shortages, it was more logical to locate midwifery in urban areas so that as many women as possible could access services. A few interviewees expressed concern over the introduction of midwifery in the North, because they felt physicians in smaller communities would be denied the opportunity to maintain their obstetric skills if a small pool of patients were divided between midwives and physicians.

I think it's probably better that the doctors in the [rural] community do the deliveries, because they can expand their care to when problems happen, whereas midwives can't. So for the safety of the women in that community, it's probably better not to take obstetrics away from the doctors that are going to have to deal with problems when the problems happen. (Participant 6)

Identifying Provincial Midwifery Research Priorities

Our second objective in the study related to identifying information and research needs for the ongoing

implementation and expansion of equitable midwifery care. The objective proved to be too ambitious to attain in a comprehensive form, at least for this study. However, widely shared concerns were noted and so were improvements. For example, participants emphasized the need for systematically recording, storing, and managing both relevant perinatal health information and socio-demographic characteristics in the initial patient history intake form. At several RHAs, the data were inconsistently gathered and stored, and just which data were being maintained or how they could be accessed was unclear. Given the close connection between proof of demand and funding at the RHA level, as well as the need for baseline data, participants felt that improvements to data collection and management at this level would be key to providing links between baseline data and maternal progress and outcomes. Such improvements would also clearly establish the numbers on the wait-list as representative of active demand for midwifery services in each RHA. Systematically collecting socio-demographic data on the intake form and storing it in an accessible way would also facilitate a more accurate analysis of the attention given to priority populations and subpopulations. Overall, participants expressed the clear need for a more systematic approach to both research and the translation of research for health regions in order to enable existing and new knowledge to inform practice and policy. Notably, participants felt that the Ministry of Health lacked a comprehensive provincial data collection and management system that could allow midwifery researchers to link utilization patterns, maternal child outcomes, and provider availability with socio-demographic information on service users. Such a system could also provide the means for an effective cross-provincial analysis of equitable access into the future. An example of these problems is that at the time of this study, data on home birth were neither routinely collected nor reported in the provincial perinatal database.

I want you to ask me how many women I have seen who are rural. How many women I have seen who are living in poverty, new immigrants? ... How many home births? How many successful water births? Those things [could] tell me, tell you, about midwifery. (Participant 5)

Secondary Analysis: Concerns and Perceptions

A secondary analysis of the data deepened our understanding of the concerns participants have given their particular experiences of implementation, and allowed us access to participants' general perceptions of equitable

access to midwifery. Although the initial and secondary analyses pointed to similar issues, the secondary analysis revealed more nuanced and personally held perceptions and concerns about equitable access to midwifery by diverse client groups. Participants most frequently and passionately cited two particular implementation concerns: (1) inadequate efforts to educate the public and (2) the failure to prioritize midwifery as a primary care service. The analysis also revealed three different interpretations of the concept of equity, all of which clearly project different policy choices.

Perspectives on Public Education and Provincial Prioritization

So, I think that in the '90s we naively thought that if we had midwives available, that would take care of the equity issue; that they would be available to the whole spectrum of the population ... it's more complex than that ... just because midwives were available doesn't mean that everyone would go looking for one. So it's a great start to have midwives available, but it's an appalling thing to think that the ... health region does nothing to educate families about the fact that midwifery care is available on an official basis. (Participant 12)

That midwifery was not widely publicized following legalization was particularly disappointing and disconcerting. And as a number of participants relayed, it is this lack of public education that breeds inequities. Indeed, that affluent and educated women seem to access midwifery more readily seems an inevitable consequence.

... you know, it is the more affluent women that can access that, know about midwifery, have made a conscious choice, and have sought out midwifery care, you know, put themselves on the list, whatever they do to get access to a midwife. What I think that we don't have enough exposure to is those midwives working in outreach services and where women can actually see what midwives do and really get an appreciation for that relationship part of it and the support part of it. And especially vulnerable women. And I don't think that we've created that access enough in the province. (Participant 14)

Participants were concerned, thus, by midwifery's quiet, "underground" (participant 8) entry, which they felt more acutely affects priority populations that often are already

encountering access barriers created by language, lack of resources, and cultural biases, and because midwifery may deviate from the system of care they previously experienced. Many participants perceive that the lack of public promotion is allowing misinformation about midwifery to stand, influencing perinatal decision making.

... in terms of other ethnic groups, they may well not be aware that it's covered or may think that they have to pay for it. (Participant 12)

Understanding the differences between the midwifery model of care and the medical model, including the concept of self-referral, is a necessary prerequisite for women to make an informed choice of a perinatal care provider. Again, interviewees expressed the belief that knowledge of the service is unequally understood in proportion to one's socio-economic status, creating a further distinction

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between the advantaged and the disadvantaged.

I think it's sort of, it still sort of feels like it's underground, even though I don't think it really is. But it, you know, it's almost like you have to sort of know somebody to find out how you would contact a midwife. Like, it's not, I don't think it's tremendously easy for people to contact a midwife. (Participant 8)

Overall, an uneasy and lingering feeling among many is that midwifery care is still provided primarily to a select demographic that is, as expressed by one participant, "well-educated, especially about women's issues and health, highly motivated to have a certain kind of birth, usually very self-advocating, usually upper-middle class Canadian women." Perhaps, as another participant suggested, a lack of publically available information means that midwifery as it is offered is a "Cadillac" service [for] a subset of the population that is looking for something different."

Public information about midwifery may create an influx of requests for midwifery (with subsequent disappointment for women unable to access it), and participants felt frustrated with managements' notion of withholding public education as a way to curb demand for services that are not yet available; participants considered this an inequitable practice that thwarts midwifery expansion. Sometimes wryly and with an all-too-frequent tone of resignation, many participants suggested that public education campaigns are unlikely to occur while provincial authorities consider midwifery a low policy priority and make it almost invisible as a primary health care service.

I think the continuity has not been there in terms of the midwifery file for government. And so what time and investment is put into really, really establishing this as a core service in this province, like a mandated service? (Participant 13)

Equity in access to midwifery is influenced by various social determinants of health, such as socio-economic position, education, age, geographic location, and ethnicity.

Although there were various levels of understanding of funding mechanisms, for some participants the absence of a committed midwifery budget at the provincial level, the problematic principle of supply and demand used for allocating funds in RHAs, and the uneven availability of care across the province support the message that midwifery care is a fringe service for a few rather than a core primary health care service. Thus, from the participants' perspective, the government is placing a price tag on equity and essentially deems it too costly to pursue.

... if there's a limited amount of money for the health system, should some of that be redirected from one sector to midwifery care? And that's kind of the big public policy decisions that need to be made here ... So the simple way of putting it is, "Is there going to be money transition from physician fee-for-service for obstetrics to support midwifery care?" (Participant 17)

Perceptions of Equity

Fundamental to exploring equity in access to midwifery care is uncovering if and how the study participants perceive, value, and conceptualize equity. It became evident during the secondary analysis that not only did participants have varying views on whether equity in access to midwifery is being realized, but also that there was considerable discordance over the definition and legitimacy of the concept.

Some participants equated equity in access to the availability of services for women seeking midwifery care. Representative of this stance, one participant stated,

I think equity should mean that if you are a low-risk patient and you want to choose a midwife as your care provider, that that option should be available to you and shouldn't be constrained by the lack of midwives that are practicing.

Equity in access here is equated with equality – the belief that women are equally equipped and knowledgeable about midwifery services and have equal means of accessing it if it is available. From this perspective, a significant barrier to equity is the lack or unequal distribution of midwives across the province. A few participants suggested that increasing availability might mean adding private-practice midwives, but most felt that private practice would create an unjust financial burden, especially for rural women seeking care, and would limit the availability of services, based on economic status; participants felt that private practice conveys a message of exclusivity surrounding midwifery care.

I don't think it's fair for women to have to pay out of pocket for midwifery care when everyone else who's near a region with midwives would have the opportunity to have it at no additional costs." (Participant 1)

In contrast to those participants likening equity in access to availability, a number of interviewees defined equity as nondiscrimination in the provision and utilization of care. These participants described equity as the intentional minimization of traditional barriers to care.

I mean equity to me means equity. No matter who you are, no matter what colour of skin, no matter who you are, there's no filter in the front door." (Participant 7)

These participants recognized the systematically unequal proportion of ill, vulnerable women to the general population and felt that more intensive services are justified. Participants with this perspective interpreted access to midwifery care as dependent not only on availability and adequate supply but also on physical accessibility in regard to, for example, services in disadvantaged neighbourhoods, flexible hours for appointments, and sociocultural acceptability in which cultural biases are minimized. In some instances, this led to participants' expanding the concept of equity in access to include all women who are struggling to access care, whether or not they fit into acknowledged categories of priority.

So equity is women being able to equally access midwifery regardless of who they are, regardless of their background ... So it's looking at women really with broad lenses, and looking at women who are struggling but not only the ones who are struggling visibly ... people are struggling financially ... they have to work, so they need flexibility in how prenatal care can be provided ... sometimes it is a lesbian woman, sometimes it is a really young woman. Sometimes it's older women who had their career and so did not have their babies at a young age and they're having their babies later in life. So really when I'm looking at equity and access, I am looking at the definition that I've been provided elsewhere, but really saying this is 2012." (Participant 5)

Participants diverged in opinion regarding whether equity in access inclusive of priority populations is obtainable or to what degree it has been achieved in Saskatchewan to date. Some noted that it was a politically correct statement but entirely unrealistic, others that it was, as stated by one participant, a "fallacy of circumstance": the intent was correct, but to achieve equitable access to care, the social determinants that create diverse and disadvantaged populations must be overcome, an impossible task within the health care arena, regardless of the model of care. Others felt that it was too soon to comment on equity in access to midwifery in Saskatchewan, because of the low number of midwives practicing in the province. According to one participant, "the sheer logic of it says there is no equity; there can't be, because there's not enough of that resource out there."

These perspectives on equity – as universal availability, redress of systemic barriers and "filters," or a system that incorporates specialized services – require further thought

and analysis, as they point to different policy responses. We found it problematic that despite the broad appeal of the concept of equity, there was no clear consensus on when and how our provincial health system and health regions should consider its incorporation into the implementation of midwifery.

DISCUSSION

Equity in access to midwifery is influenced by various social determinants of health, such as socio-economic position, education, age, geographic location, and ethnicity.^{14,15} The importance of social and cultural fit with the care provided has proven to be exceptionally important for Aboriginal women¹⁶⁻¹⁸ and for socially marginalized women,^{16,19-22} as culturally appropriate services have been shown to affect both birth outcomes and the quality of birth experiences. Studies have also shown that various determinants of equitable access to midwifery care in Canada relate to legislation and organization^{19,23-25} as well as to scope, standards, and practice arrangements.^{16,19} These are modifiable determinants contingent on governmental priority, funding, programs, and the like. Our research indicates that even though general commitments to equity in midwifery access are enshrined in Saskatchewan's health care policies and midwifery regulations using the language of priority populations, significant (yet modifiable) barriers to equity in access to care currently exist, and such priority populations are not being provided with adequate services under current arrangements. There are various reasons for these barriers, but we believe they stem from three major issues: (1) unclear operational definitions, (2) lack of prioritization and planning for a rollout of equitable province-wide midwifery services, and (3) inadequate public and interprofessional education about midwifery.

Definitional and operational issues plague the system. Exactly what should "priority populations" be in the case of midwifery, and what are reasonable targets and – more important – the specific mechanisms for reaching those populations and making service available to them? How does the system enact policies of equity in access if its decision makers and practitioners differ on what they believe this entails and whether it is even desirable at this stage of implementation?

While participants were invariably happy to finally see midwifery being implemented in the province, all suggested that it is rolling out unevenly. As is, the participants in this study considered a large part of the problem to be in simply setting straight the provincial priority. The provincial

government and health authorities have insufficiently prioritized, publicized, planned, and supported the emergence of a vibrant and growing midwifery service for diverse groups of Saskatchewan women. Currently, midwifery is almost invisible in provincial documents relating to primary care, and little is being done to facilitate a systematic documentation of midwifery demand or midwives' perinatal outcomes. Invisibility is fuelling misinformation and slowing the growth of midwifery, particularly as a service for priority populations. It is also diminishing the potential uptake by RHAs, which are often unsure of how to incorporate new services and models of care. To attribute the difficulties in rolling out equitable access to midwifery to the low numbers of midwives in the province is simplistic, circular, and victim blaming. Much more can and should be done.

Equity in health care is most simply defined as the absence of avoidable disparities in health and systemic barriers to it.

While our study was small, exploratory, and focused on these early years of provincial implementation, it uncovered a series of systemic barriers to equitable access to midwifery in the province for which we were able to generate policy recommendations and considerations. It is important that the data were collected and analyzed and our report constructed throughout 2012 and early 2013, and it is encouraging that some of our results have already catalyzed or contributed to changes that have taken place since then. Still, follow-up research on client perspectives and the unique needs and aspirations of Aboriginal midwifery are needed, as are intervention studies earmarked to follow those interventions designed to address equity concerns.

The study also begs the larger questions of future research and discussion. Thus we might ask, How much can concerns with equity and accessibility shape the way the Canadian model of midwifery is practiced at both the individual level and system level? For although the Canadian midwifery model is conducive to equitable access, it alone cannot create it. On the contrary, as we have seen in Saskatchewan, the model sometimes is retrofitted to accommodate competing economic and political interests and priorities in the health systems into which midwifery

is inserted. Given that reality, especially in the midst of our current national and provincial debates about health care funding and priorities, how can equitable, accessible midwifery gain ground?

CONCLUSION

Equity in health care is most simply defined as the absence of avoidable disparities in health and systemic barriers to it.²⁶ However, equity is not just about access to services but also about the quality of care once they are accessed.^{20,21,27} Equity and access to care are inextricably linked, as both are rooted in the social, economic, and political context of the system in which service is delivered.^{26,28,29} This first Saskatchewan study of the contexts and experiences of implementation uncovered key policy issues and decision-making processes that are propitious for an uneven rollout of midwifery services. However, it has also catalyzed positive responses and changes, and we invite members of the midwifery community to continue to document and share those changes.

The first phase of this research described many insightful and important midwifery policies and activities with which provinces have experimented to fulfill their equity mandates. We believe that if there were a recipe for the equitable implementation of midwifery, it would include and go beyond these experiments. Policy informed by sound evidence and conceptual clarity, RHAs with the liberty and will to fund and support innovative practice arrangements, and intense public education about midwifery are but a few of the needed ingredients.

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