

# Ontario Midwifery Program

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## BACKGROUND

The Ministry of Health and Long-Term Care's Community and Health Promotion Branch is responsible for administering and funding the Ontario Midwifery Program.

On December 31, 1993, midwifery became a regulated health profession in Ontario. The *Midwifery Act* defines the practice of midwifery as the assessment and monitoring of women during pregnancy, labour and the post-partum period and the provision of care to women and their babies during normal pregnancy, labour and post-partum period.

The Ontario Midwifery Program was established in 1994 to fund professional midwifery services. Based on information provided by midwifery practice groups, the Ministry estimated that midwives attended approximately 3,800 births in the 1998/99 fiscal year. By the 2003/04 fiscal year, the Ministry expects that midwives will be attending about 12,000 births annually in the province.

For the 1999/2000 fiscal year, the Ministry provided approximately \$17 million to fund the provision of midwifery services.

## AUDIT OBJECTIVES AND SCOPE

The objectives of our audit of the Ontario Midwifery Program were to assess whether the Ministry had adequate procedures in place:

- to ensure that the Program was managed with due regard for economy and efficiency; and
- to measure and report on the effectiveness of the Program.

Our audit was performed in accordance with the standards for assurance engagements, encompassing value for money and compliance, established by the Canadian Institute of Chartered Accountants and accordingly included such tests and other procedures as we considered necessary in the circumstances. Prior to the commencement of our audit, we identified the audit criteria that would be used to address our audit objectives. These were reviewed and agreed to by senior ministry management.

In conducting our audit, we reviewed and analyzed program policies and procedures, interviewed ministry staff and met with representatives of the College of Midwives of Ontario and the Association of Ontario Midwives. We were unable to rely on the Ministry's Internal Audit Service to reduce our audit work since it had not issued any recent relevant reports on the Program. Our audit covered the period up to May 2000.

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## OVERALL AUDIT CONCLUSIONS

The Ministry had developed a new funding agreement for midwifery practice groups that meets the essential requirements of Management Board of Cabinet's Directive on Transfer Payment Accountability. However, the Ministry had not yet developed the procedures necessary to ensure that the expanding Ontario Midwifery Program is being managed with due regard for economy and efficiency and to measure and report on whether the Program is meeting its goals and objectives. Specifically, we found that the Ministry had not:

- assessed whether the current delivery and funding model for midwifery services was cost effective;
- instituted a process to collect and analyze information needed to evaluate the success of the Program;
- defined greater equity of access to midwifery services; and
- assessed the appropriateness of the process used to refer midwifery clients to specialists in non-emergency situations.

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## DETAILED AUDIT OBSERVATIONS

In 1987, the Task Force on the Implementation of Midwifery in Ontario recommended to the Minister of Health that midwifery be established as a regulated health profession. In 1993, the *Midwifery Act* was proclaimed, and midwifery became a regulated health profession in Ontario. Under the *Regulated Health Professions Act*, the College of Midwives of Ontario was established as the governing body for midwifery in Ontario. The College's responsibilities include:

- regulating the practice of the profession and governing the members in accordance with legislation, regulations and by-laws;
- developing, establishing and maintaining standards of qualification for midwives; and
- developing, establishing and maintaining programs and standards of practice to assure the quality of the practice of the profession.

In 1994, the Ontario Midwifery Program was established to fund midwifery services with the goals of improving maternal and child outcomes and providing choice in maternity care through managed, community-based midwifery services. The Program's objectives include ensuring:

- consumer involvement in the planning, delivery and evaluation of services;
- greater equity in access to midwifery services across Ontario; and
- an equitable funding mechanism that supports the integration of midwifery services into the funded health care system.

From 1994 to 1999, on an interim basis, the Ministry had contracted with and funded a non-profit agency, which in turn had agreements with midwifery practice groups to provide services in specific geographic areas. Practice groups are usually made up of two to five midwives.

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In 1999, the Ministry approved 20 non-profit agencies that, effective April 1, 2000, replaced the previous single non-profit agency. As part of the transfer to 20 agencies, the Ministry developed a new funding agreement for use by these agencies and their practice groups that meets the essential requirements of Management Board of Cabinet's Directive on Transfer Payment Accountability. In January 2000 there were 39 midwifery practice groups and approximately 180 registered midwives. The Ministry expects the number of registered midwives to grow by 40 to 50 a year as new graduates enter the profession.

Most of the funding a practice group receives is based upon the number of billable courses of care provided. A billable course of care usually refers to the midwifery services provided to a client. However, a billable course of care may also include other activities, such as outreach activities directed to populations with special health care needs. Billable courses of care that do not involve the provision of midwifery services are subject to specific conditions and limitations and must be approved by the Ministry in advance.

The fee for a billable course of care includes a fixed component of \$575 to cover overhead costs and a professional component that varies with the midwife's number of years of experience. For example, the professional component for a midwife with five years experience is \$1,575. Certain expenses, such as travel, are reimbursed separately.

## **ASSESSING COST EFFECTIVENESS**

Information about cost effectiveness is important in assessing the funding and organization of midwifery services since these arrangements affect the cost of delivering these services.

In 1996, the Ministry, the College of Midwives of Ontario and the Association of Ontario Midwives identified the need to develop an Information Management and Technology Plan for the Program. Consultants were engaged and made recommendations for a shared information system that would meet the needs of all three parties. At the time of our audit, the Ministry had not acted on these recommendations.

In 1997, the Ministry funded a study to make preliminary cost comparisons between midwifery care and family physician maternity care using health data from ministry systems, such as OHIP. However, the study was never completed. An evaluation of cost effectiveness would also have to address the quality of care provided, for instance, whether midwifery reduces the incidence of interventions such as cesarean sections and hospital stays when compared to physician-attended low-risk pregnancies.

At the time of our audit, the Ministry did not have adequate information to effectively monitor and determine whether the objectives of the Midwifery Program were being met. While the Ministry received quarterly activity reports containing caseloads and number of births, it did not obtain sufficient information about the outcomes of midwifery services.

Recognizing the need for data on the utilization of resources and outcomes, the Association of Ontario Midwives began to collect data from midwifery practice groups on a voluntary basis. Although data has been collected for 1998 and 1999, the Association has indicated that it has insufficient resources to compile and analyze it.

Information about the quality and cost effectiveness of midwifery services is also an important element in health workforce planning. In a December 1999 report on physician resources in Ontario, a provincially appointed fact finder noted that physician workforce planning cannot

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occur in isolation since it is influenced by many factors, including the role of other practitioners with overlapping scopes of practice. The fact finder also noted that future planning for and funding of midwifery needed to be integrated with overall planning for obstetrics services.

### **Recommendation**

**To help assess the quality of midwifery services and assess whether these services are delivered efficiently and effectively, the Ministry, along with the College of Midwives of Ontario and the Association of Ontario Midwives, should:**

- determine what information is needed to make these assessments; and
- ensure that the information is collected and analyzed.

### **Ministry Response**

*The Ministry will work with the Association of Ontario Midwives and the College of Midwives of Ontario to develop an evaluation system and management information system to assist in the assessment of the efficiency and effectiveness of midwifery services delivered through the Midwifery Program. This type of health program effectiveness research is complex and requires extensive comparative data from other parts of the health care sector. Current limitations in the available data may affect the Ministry's ability to make valid comparisons.*

*Since 1996, the Ministry has been developing comprehensive funding agreements for midwifery practice groups and transfer payment agencies; revising the program's reporting systems, policies and procedures; and devolving funding to 20 local transfer payment agencies. The Ministry will now embark on developing an evaluation tool for the Midwifery Program. As a first step, the Ministry will ensure that the evaluation and management information needs of all stakeholders are identified. The Ministry will then develop a system to gather data from midwifery service providers, aggregate it at the local and provincial levels and provide reports to midwifery stakeholder agencies and the public.*

## **EQUITABLE ACCESS**

One of the objectives of the Midwifery Program is to ensure greater equity of access to midwifery services across Ontario. However, the Ministry has not defined "greater equity of access." If decisions about access are to be made, the Ministry requires information about who has access to midwifery services now.

As of April 1, 2000, the new funding agreement requires midwifery practice groups to offer and provide services to a minimum number of women referred to the group by their local approved agency. This number is negotiated between each practice group and its agency. If some agencies reserve for their clients a significant number of places within midwifery practice

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groups, this decreases the number of spaces available to others. Ministry staff indicated that they would not be receiving copies of the agreements between the local agencies and their practice groups. Therefore, the Ministry will not be able to monitor or assess the impact of this process on access to midwifery services.

In 1987, the Task Force on the Implementation of Midwifery in Ontario stated that midwifery services should be equally accessible to all women and recommended that midwives be prohibited from seeking or obtaining payment for midwifery services from their clients. While the agreements with midwifery practice groups and the College of Midwives of Ontario's regulations prohibit midwives from accepting payment from a client for services paid for by the Ministry, midwives are not prohibited from having private clients. Therefore, it is possible that clients who are willing to pay more than the Ministry pays will have greater access to services.

Unlike for physicians' services, to receive publicly funded midwifery services, a woman does not need a valid health insurance number. However, to be eligible to obtain publicly funded midwifery services, a woman must be resident in the service area described in the funding agreement. The funding agreement simply defines a resident as "a female person who is a resident in the service area." This contrasts with the detailed definition of "resident" used for the purposes of determining eligibility for other ministry programs such as OHIP.

### **Recommendation**

**To determine whether the Midwifery Program is meeting its objective of ensuring greater equity of access to midwifery services, the Ministry should:**

- **clearly define the meaning of "greater equity of access";**
- **assess the impact of the allocation of midwifery services in the agreements between local agencies and midwifery practice groups;**
- **review the arrangements that permit midwives to have private clients;**  
**and**
- **clearly define "resident" for the purposes of eligibility for publicly funded midwifery services.**

### ***Ministry Response***

***Prior to 1994, midwifery services were available only to women and families who could afford to pay privately. One of the objectives in establishing a publicly funded midwifery program was to improve equity of access by ensuring that ability to pay was not a barrier to access. As the number of midwives increases, the service will be made accessible to more women in more locations across the province. The Ministry will assess whether the objective of a publicly funded midwifery program should be revised to more clearly reflect the intention.***

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***As part of the Program's mandate, funding has devolved from one central to 20 local transfer payment agencies. These agencies are well positioned to have a broad overview of the service needs of their local populations. The funding agreement requires agencies to negotiate with each practice group the number of clients the agency may refer to it in any year. The intent of this requirement is to create greater equity of access since the agency will refer women who it identifies as having special needs or who may otherwise have been unable to obtain midwifery care on the usual first-come first-served basis. The Ministry monitors the allocation of midwifery resources and their utilization throughout each year through quarterly reports provided to the Ministry.***

***Transfer payment agencies fund midwives in accordance with an agreement that establishes midwives as independent contractors. One important legal element inherent in this model is the ability of midwives to determine how and from whom they derive their income. The Ministry will monitor whether this has any impact on access to midwifery services.***

***The Ministry notes that there are many definitions of resident in different pieces of health care legislation that are used for many different purposes. The Ministry will review the residency definition to ensure that it meets the needs of the Midwifery Program and therefore the population being served.***

## REFERRALS TO SPECIALISTS

The Task Force on the Implementation of Midwifery in Ontario recommended that the College of Midwives of Ontario develop standards of practice for midwives, including criteria for consultations with and referrals to physicians. Accordingly, the College developed guidelines requiring midwives to consult and transfer care to a physician under specific conditions. Midwives are also required to consult with a physician when specific health conditions are present during pregnancy, labour and birth or during a period of at least six weeks after birth.

Since the inception of the Program, the College and the Association of Ontario Midwives have expressed concerns to the Ministry about the difficulties some midwives have experienced in directly consulting with medical specialists when, according to their professional standards of practice, consultation was required. Instead, midwifery clients generally needed to be referred to a specialist by a family physician.

In its April 30, 1996 report on primary health care, the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations recommended to the then Minister of Health that midwives be allowed to make referrals directly to some specialists, for example, obstetricians.

In April 1999, the Ministry created two OHIP fee codes for emergency assessments of clients of midwives. We were informed that midwives continued to have difficulty directly accessing specialists in non-emergency situations. In these situations, midwifery clients generally needed to be referred to a specialist by a family physician or hospital emergency department. The current referral practice may create additional costs for the health care system and

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inconvenience women and their children, such as requiring them to make unnecessary visits to family physicians and hospital emergency wards.

**Recommendation**

**The Ministry should ensure that the current process for referring clients of midwives to specialists does not result in unnecessary visits to family physicians or hospital emergency departments.**

***Ministry Response***

***The family physician's role in the medical system cannot be overestimated. They help ensure that patients receive the best possible care and reduce pressure on scarce specialist resources. Nonetheless, direct referrals from midwives to specialists are appropriate under certain circumstances. The Ministry agrees to raise the associated professional and payment policy issues with stakeholders within the College of Physicians and Surgeons of Ontario, the Ontario Medical Association, the College of Midwives of Ontario and the Association of Ontario Midwives and work toward a resolution.***