ASK AN EXPERT

Health Science Inquiry

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A Failure of Access?:
The Birth Evacuation Policy in Canada's North

The primary policy objective of the Canada Health Act is to maintain and improve the health of Canadians [1]. Under this Act all residents are entitled to reasonable and equitable access to all medically necessary hospital and physician care, free at the point of service. In practice, however, universal and equal health care access is challenged in Canada by a variety of factors, including difficulties in staffing availability and providing cost-effective services in rural and remote areas. Maternity care is one such medically necessary service that is not always reasonably and equally accessible. In the current health care delivery model, patients in remote areas of Canada often need to travel long-distances between communities or go south to access both specialized and standard maternity care. Since the 1980s, pregnant women in most Inuit communities, regardless of health risk, are flown to southern cities such as Iqaluit, Winnipeg, Ottawa, and Yellowknife to deliver approximately four to six weeks prior to their due date [2, 3].

The costs of this obstetric evacuation policy are high in terms of the emotional, social and cultural costs to mothers and their communities. The costs of air travel to these remote regions mean that pregnant women usually travel alone, separated from their support system while they wait to deliver their child. For women who travel to Manitoba, Ontario or Quebec to deliver, there is the added stress of adapting to a different culture and language. Women have reported isolation, anxiety, stress, sadness and loneliness associated with this policy [4, 5]. Reported instances of women hiding their pregnancies, lying about due dates, refusing to leave the community and deciding to give birth on their own, demonstrate a preference for delivering within the community.

Furthermore, although this policy certainly improved outcomes for high-risk pregnancies, no conclusive evaluation of the effects of this policy exists for non-high-risk pregnancies. Although there is some evidence that there have been improvements in pregnancy outcomes associated with the policy, its implementation coincided with the provision

of a variety of other new services that would have simultaneously contributed to positive outcomes [5]. In contrast, some studies have found no evidence of poorer health outcomes among community births relative to evacuated births [6]. Further, there are growing reports that suggest evacuation may contribute to post-partum depression, increased intervention and higher rates of maternal and newborn complications [7, 8].

While 'reasonable access' has not been defined in the Canadian Health Act, the high costs and uncertain benefits associated with the birth evacuation policy suggest that although women in remote areas have access to this necessary care, access may not be 'reasonable'. As such, both the Society of Obstetricians and Gynecologists of Canada and communities have advocated for the return of delivery services to rural and remote Indigenous communities [7]. The success of community midwifery clinics across Nunavik and specifically in Rankin Inlet provide a viable alternative to evacuation for low-risk pregnancies. These birthing centres are situated in larger communities, meaning some women do have to travel for maternity services, but they are significantly closer to home and within a familiar culture.

Finally, we note that universal health care access is not enough to equalize health outcomes across social gradients. There are well-documented and sustained disparities in birth and maternity outcomes in Inuit-inhabited areas compared to all other areas and particularly rural areas of Canada [9], demonstrating that birth evacuation has not equalized birthing outcomes. To understand these large inequalities, an examination of the structural determinants of health is necessary. These determinants related to historical and political processes that generate and maintain social hierarchies that drive health inequalities. For example, colonizing policies, such as the residential school policy and relocation programs, have prolonged political and economic disadvantage for Indigenous Canadians, manifesting in large disparities in employment, education, income, and housing. While it is critical to address existing disparities in access to health care such as maternity care, lasting change can only be achieved through action on these fundamental social determinants of health.

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