POLICY BRIEF
Women and Children Last:
An Examination of Canada's Maternal Care Crisis

Bacchus Barua | November 2026



Executive Summary

Across Canada, signs of an imminent health care crisis abound. Long wait lists, emergency room closures, and burned-out health care staff have become the norm. While these challenges permeate across the board, some types of care are being identified as particularly vulnerable to what may be devastating consequences. This policy brief examines the availability and quality of maternal care – i.e., care provided to expectant and new mothers – as well as its implications for their newborn children.

Key findings include:

1. Canada faces a relative shortage of maternity care providers. In 2024, Canada ranked close to the bottom (34th of 36) for obstetricians and gynaecologists [OB-GYNs] and tied for last among 24 countries for licensed midwives, according to data from the Organisation for Economic Co-operation and Development [OECD]. Combined, countries like Sweden have more than eleven times the availability of these maternity care professionals compared to Canada (1.5 per 1,000 inhabitants vs 0.13).

2. Timely access to gynaecological care has deteriorated substantially. The median wait time from referral by a family doctor to receiving treatment grew from 14.8 weeks in 2005 to 40.6 weeks in 2025 – a 174% increase.

3. Maternal mortality in Canada is worsening while peer countries improve. In 2024, Canada's maternal mortality rate reached 12.6 deaths per 100,000 live births, worse than the OECD average of 8.7 and ranking 30th out of 36 for performance (i.e. Canada had the seventh highest mortality rate). While the OECD average has improved over the past two decades (from 11.5 to 8.7), Canada's rate has worsened (from 8.8 to 12.6).

4. Canada performs poorly on several key maternal health indicators compared with peer countries. Among 11 Commonwealth Fund comparator countries, Canada ranked at or near the bottom for its performance on maternal mortality and obstetric trauma (i.e. it reported among the highest rates). Canada's maternal mortality was approximately seven times worse than Norway's (12.6 per 100,000 live births vs. 1.8), while its rate of obstetric trauma with an instrument was more than four times higher than the Netherlands (16.1 per 100 deliveries vs. 3.8).

5. Infant outcomes in Canada also lag behind many comparable countries. Canada reports higher (i.e. worse) rates of low-birth-weight deliveries, infant mortality, and perinatal mortality than many peers. In Canada, 7.2 percent of babies were born with a low birth weight, compared with only 4.1 percent in Sweden. Canada ranked ninth worst (out of 11) for neonatal mortality and infant mortality, with an infant mortality rate of 4.5 per 1,000 live births, more than double Sweden's rate of 2.0.

Background

On May 20, 2025, Danielle Goward went into early labour at Cariboo Memorial Hospital in Williams Lake, BC. In the preceding weeks, she had been informed that a shortage of specialists and the complexity of her pregnancy meant she would need to be transferred to deliver her twin girls. She thought that meant a coordinated flight to a well-staffed hospital when the time came. Instead, she was shuffled between four hospitals in 12 days – an experience Goward called "terrifying" in a story recounted to the Globe & Mail.[1] Unfortunately, Goward is just one of many mothers being failed by her provincial health care system.

Around the same time, doctors from one of the hospitals at which Goward was denied care issued a statement declaring, "the safety of patients and newborns at Kelowna General Hospital [was] at serious risk".[2] In October, seven obstetrician gynaecologists (OB-GYNs) in Kamloops resigned in protest due to potentially unsafe work conditions that rendered them, "unable to continue with in-hospital care".[3] Their resignations were supported by the CEO of Interior Health and 128 physicians in a letter to the Minister of Health.[4]

The challenges with access to OB-GYNs are not confined to rural areas. Earlier this year, the maternity unit at Peach Arch Hospital in White Rock, BC faced multiple closures, and even Vancouver General Hospital announced pregnant patients requiring emergency or specialist care would be diverted due to a lack of on-call OB-GYNs.[5, 6]

While stories like these have become commonplace in BC, other provinces face similar challenges. For example, in November of 2025, Cold Lake Health Care Centre in Alberta announced they would be unable to provide obstetrical service until early January of the following year; the obstetrical unit at Georgian Bay General Hospital in Ontario reported multiple temporary closures in 2026; and the obstetrics unit at Lac-Mégantic in Quebec was suspended for almost a year.[7, 8, 9]

These stories suggest an impending catastrophe on the horizon for Canadian mothers and their newborns at the most vulnerable and precious moments of their lives. This policy brief seeks to document Canada's relative availability of maternal care specialists as well as the quality of outcomes and health status for mothers and newborns.

Taking Stock: Availability of OB-GYNs and Midwives

The journey through pregnancy and childbirth involves several health care professionals: family doctors, nurses, anesthetists, and emergency care physicians, among others. While ongoing challenges accessing family doctors, nursing shortages, and emergency room closures are well documented, media and policymakers have only recently begun paying attention to those two classes of health care workers specifically focused on maternal health and childbirth: midwives and obstetrician-gynecologists (OB-GYNs).

Unfortunately, data from the OECD suggests Canada faces severe shortages of both.[10]

Midwives are typically primary-care providers for low-risk pregnancies, but they may also be permitted to provide care during pregnancy, childbirth, and after delivery at designated hospitals. In 2024, out of 24 countries, Canada tied for last in the number of licensed midwives per capita.[a]

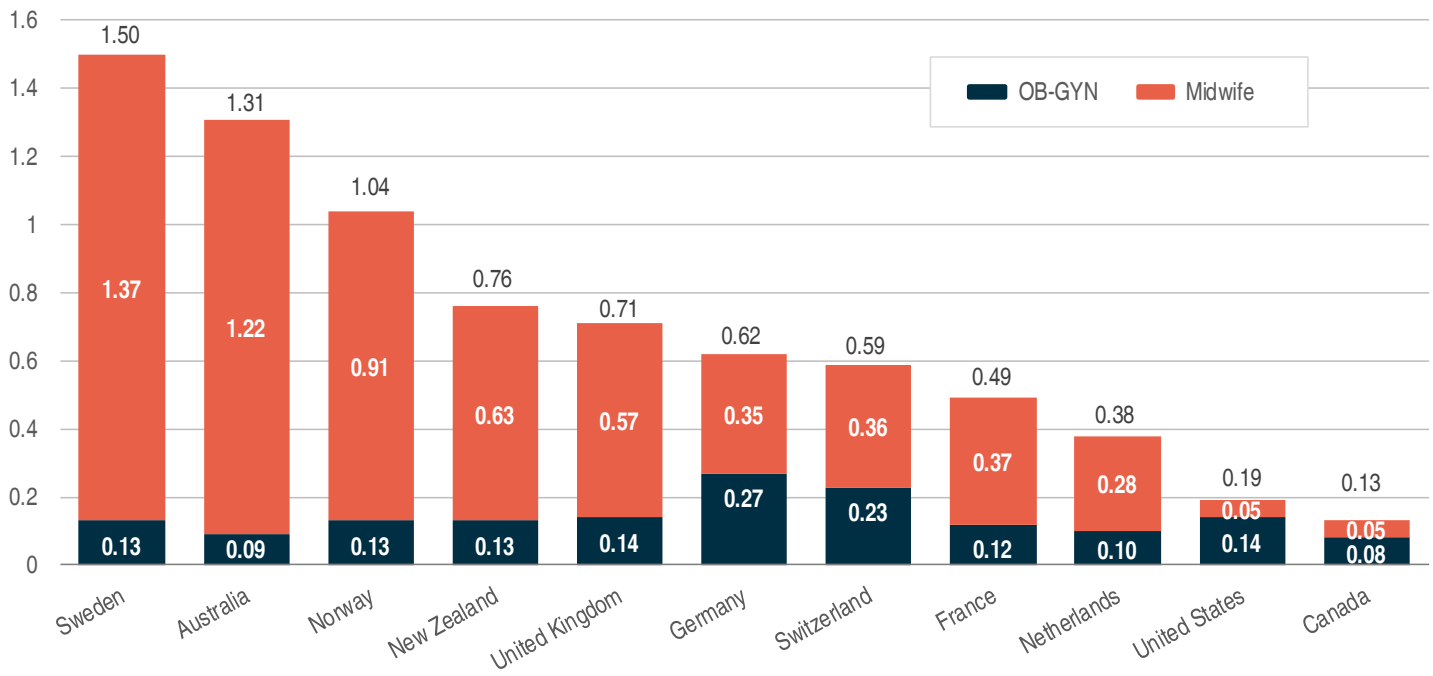
While troubling, this may not necessarily be a problem with countries that rely to a greater extent on OB-GYNs, who are specialist physicians usually involved in higher-risk pregnancies. However, data from the OECD indicates that Canada also ranked near the bottom (34th of 36) for the relative availability of OB-GYNs.[b] Taken together, these findings suggest a relatively limited maternal care workforce.

a Data for the United Kingdom is for 2020, while data for the United States is for 2016. Data is for midwives licensed to practice where available. Data for professionally active midwives is used for France, Germany, Japan, Portugal, Slovenia, and Turkey. Data for practicing midwives is used for Czechia, Greece, and Switzerland.

b Data for the United States is for 2022.

Figure 1

OB-GYNs and Midwives, per 1,000 Inhabitants, 2024 (or most recent year)



Source: OECD Health Statistics, 2026; calculations by author.

The Commonwealth Fund routinely performs comprehensive international comparisons of health care systems for a cohort of 11 peer countries.[11] It has also published comparative analyses on maternal care among these countries, most recently in 2020 and 2024, using the United States as the primary point of comparison.[12, 13] Applying a similar methodology to the same set of countries (hereafter referred to as *peer countries)*, we developed an updated measure of the maternal care workforce, defined as the combined number of midwives and OB-GYNs per 1,000 people. Using data for 2024 (or the most recent year), we find Canada ranks 11th of 11, placing last[c] (Table 1). Sweden ranks first among peer countries, with 1.5 mid-wives and OB-GYNs per 1,000 people – more than 11 times as many as Canada (0.13) (Figure 1).

In other words, while some countries (like Sweden) may rely on a midwifery-care model and others (like Canada and the United States) on a surgical focused OB-GYN model, Canada has a relative, and acute, shortage of both midwives and OB-GYNs (Table 1).

Wait Times for Gynaecologists

Given the relative shortage of OB-GYNs in Canada, it should come as no surprise that patients often face significant wait times to access one. Gynaecologists are physicians who specialize in women's reproductive health. While not all gynaecologists are obstetricians or trained for pregnancy related care, most in Canada are trained for both.[14] The OECD and Canadian Institute for Health Information (CIHI) typically group gynaecologists, obstetricians, and OB-GYNs together, but because wait-time data tends to be reported for gynaecologists, it is unclear whether this explicitly excludes

c Data is for midwives licensed to practice, except for France and Germany (professionally active), and Switzerland (practicing).

Table 1

OB-GYNs and Midwives, per 1,000 Inhabitants, 2024 (or most recent year)

Country	OB-GYN	Midwife	Total Maternal Workforce	Rank
Australia	0.09	1.22	1.31	2
Canada	**0.08**	**0.05**	**0.13**	**11**
France	0.12	0.37	0.49	8
Germany	0.27	0.35	0.62	6
Netherlands	0.10	0.28	0.38	9
New Zealand	0.13	0.63	0.76	4
Norway	0.13	0.91	1.04	3
Sweden	0.13	1.37	1.50	1
Switzerland	0.23	0.36	0.59	7
UK	0.14	0.57	0.71	5
US	0.14	0.05	0.19	10
Average	**0.14**	**0.56**	**0.70**	

Source: OECD Health Statistics, 2026; calculations by author.

obstetricians and OB-GYNs. Regardless, timely access to gynaecologists is a critical component of women's health and an important indicator of the accessibility of maternal and reproductive health services more broadly.

Consider the story of Rebecca Goodine, a 31-year-old patient in Halifax documented by the CBC.[15] Following years of pelvic pain and heavy menstrual periods, visits to a private clinic (due to an absence of a family doctor), and a lost referral, Goodine finally got on an official wait list to see a gynaecologist in 2025. The expected wait? Three to four years.

While this wait time may seem unusually long, it is supported by data from the Fraser Institute which reported a median wait of 104 weeks to see a gynaecologist in Nova Scotia in 2025 (never mind the wait to actually get treated). While Nova Scotia reported the longest wait in Canada, the national wait to see a gynaecologist was 25 weeks (about half a year), and patients are expected to wait a further 15.6 weeks to actually receive treatment.[16] Overall, the typical patient faces a wait time of 40.6 weeks from referral by a general practitioner (GP) through seeing a gynaecologist to eventually receiving treatment. By contrast, this same pathway saw a median wait time of 20.5 weeks in 2015 and 14.8 weeks in 2005 (Figure 2).[17, 18]

While not every patient requiring gynaecological care is seeking pregnancy-related services, women in Canada clearly face considerable delays and lengthy wait times in accessing physicians who are specialized in reproductive health and medicine.

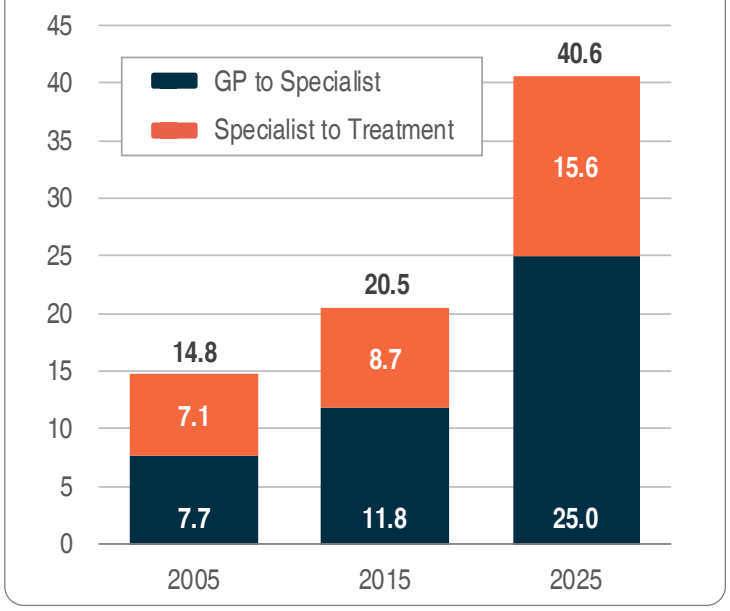
Outcomes and Health Status

The relatively low availability of midwives and OB-GYNs combined with long wait times to care raises significant concerns about quality of care and outcomes for mothers and newborns. Readers should note that lower rates are preferable for indicators presented here, and ranking is reflected accordingly for performance (i.e., rank 1 = best).

Maternal mortality is a key indicator of maternal health outcomes, defined by the OECD as, "the death of a woman

Figure 2

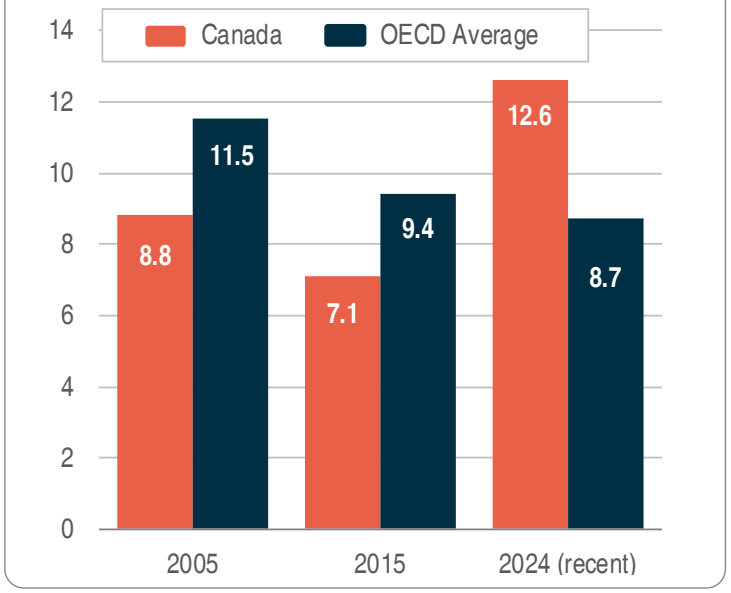
Wait Times (Weeks) GP Referral to Gynaecology Treatment, 2005, 2015, 2025



Source: Fraser Institute's annual Waiting Your Turn reports (2005, 2015, 2025).

Figure 3

Maternal Mortality, 2005-2024: Deaths per 100,000 live births, Canada vs OECD



Source: OECD Health Statistics, 2026.

during pregnancy or childbirth, or within 42 days of the termination of pregnancy." The data presented here clearly shows that Canada's maternal mortality rate is higher (i.e., worse) than the OECD average and has deteriorated over the past 20 years (albeit, with a small improvement in between). This is corroborated by another recent study in the Lancet that examined 204 countries and territories and found "Canada's maternal deaths increased 18% from 2015 to 2023."[19, 20] This trend raises concerns about the effectiveness of maternal health care and outcomes for expectant mothers.

Although Canada's maternal mortality rate was lower (i.e., better) than the OECD average in 2005 (8.8 deaths per 100,000 live births vs. 11.5) its international ranking for performance on this indicator was relatively poor (25th worst out of 36).[d] By 2015, maternal mortality rates had improved in both Canada and across the OECD, although Canada maintained its rank.

By 2024, Canada's maternal mortality rate had risen to 12.6 deaths per 100,000 live births, worse than the OECD average of 8.7 and the seventh highest overall (placing Canada 30th worst of 36 countries for performance). Simply put, while the maternal mortality rate declined (i.e. improved) across the OECD between 2005 and 2024, Canada's rate moved in the opposite direction (i.e. worsened), suggesting a deterioration in maternal health outcomes relative to many of its peers (Figure 3).

As can be seen in Table 2, in 2024 among the 11 peer countries identified by the Commonwealth Fund, Canada ranked tenth for performance with a mortality rate that is seven times worse than in top-performing Norway.

Canada also performs poorly on indicators of obstetric trauma – i.e. the rates of third- and fourth-degree vaginal tears during delivery. In 2023, Canada reported the highest rate

d The high OECD average was driven by extremely high reported mortality rates in countries like Colombia, Mexico, and Turkey in 2005. Readers should also exercise caution when interpreting maternal mortality rate for countries with smaller populations such as Latvia, Lithuania, and Slovenia which are susceptible to large variation driven by a small number of events (or their absence).

Table 2

Maternal Mortality and Obstetric Care

Country	Maternal mortality per 100,000 live births 2024 (or most recent)	Obstetric trauma vaginal delivery with instrument per 100 deliveries 2023 (or most recent)	Caesarean section, per 1,000 live births 2023 (or most recent)
Australia	8.1	5.3	407.4
Canada	12.6	16.1	327.4
France	8.2	—	210.8
Germany	4.4	6.5	317.6
Netherlands	3.6	3.8	158.7
New Zealand	6.7	6.0	316.0
Norway	1.8	4.4	159.1
Sweden	5.2	9.4	185.1
Switzerland	7.7	7.4	332.6
UK	8.3	6.0	398.5
US	17.9	11.7	323.1
Peer Average	**7.7**	**7.7**	**285.1**
Canada Rank (1=best)	**10**	**10**	**8**

Source: OECD Health Statistics, 2026.

(i.e. worst) of obstetric trauma (with or without an instrument) among the 27 countries for which data was available (Table 3). Among the Commonwealth Fund peer countries, Canada's rate of obstetric trauma involving instruments was 16.1 per 100 deliveries, more than four times the rate reported in the Netherlands (3.8) (Table 2).

Caesarean section rates provide another indicator of maternal health outcomes, although the interpretation is not as straightforward. While some expectant mothers may voluntarily opt for this method of delivery, these surgeries are often necessary and lifesaving. The OECD notes that higher rates of caesarean deliveries may be associated with increased risks for the mother and child, as well as increased complications for future deliveries.[21] Furthermore, evidence from the WHO suggests that caesarean section rates higher than ten percent are not associated with reductions in maternal and newborn mortality rates.[22]

In 2023, Canada reported 327.4 inpatient caesarean deliveries per 1,000 live births (32.7%), exceeding the OECD average (28.5%). While caesarean section rates have risen across developed countries and no country in the OECD reported rates under 10%, Canada's rate remains high by international standards. Among the Commonwealth Fund's 11 country comparator group, in terms of caesarean deliveries per 1,000 live births, Canada reported rates roughly double those reported in the Netherlands and Norway (15.9 % each) (Table 2). Again, this indicator should be interpreted with caution.

Table 3

Birth Outcomes and Early Childhood Mortality

Country	Low Birthweight—Percentage of live births, 2024 (or most recent)	Perinatal Mortality—Deaths per 1,000 births, 2024 (or most recent)	Neonatal Mortality—Deaths per 1,000 births, 2024 (or most recent)	Infant Mortality—Deaths per 1,000 live births, 2024 (or most recent)
Australia	6.6	4.9	2.4	3.3
Canada	7.2	5.8	3.3	4.5
France	7.5	11.2	2.9	4.1
Germany		5.6	2.4	3.3
Netherlands	5.6	4.2	2.6	3.3
New Zealand	7.0	6.6	4.0	5.6
Norway	4.4	2.9	1.6	2.1
Sweden	4.1	4.2	1.4	2.0
Switzerland	6.0	6.7	2.7	3.3
UK	7.2	6.1	3.1	4.2
US	8.5	5.4	3.7	5.5
Average	**6.4**	**5.8**	**2.7**	**3.7**
Canada Rank (1=best)	**10**	**11**	**11**	**11**

Source: OECD Health Statistics, 2026; calculations by author.

Measures of infant and newborn health also point to comparatively weaker outcomes in Canada (Table 3). In 2023, 7.2 percent of live births in Canada had a weight of less than 5.5 pounds (the threshold for low birth weight). This is higher (i.e. worse) than the 6.7 percent OECD average.[e] Among the ten Commonwealth Fund peer countries with available data, Canada ranked seventh worst on this measure, while Sweden reported only 4.1 percent born underweight.

Mortality indicators are even more concerning. A previous study co-written by the author of this report found that in 2021, Canada had significantly higher (i.e. worse) infant and perinatal mortality compared to the average high-income universal health care country.[23] More recent international data suggests that these challenges persist. Canada ranked 23rd worst (of 34) for perinatal mortality,[f] 29th worst (of 36) for neonatal mortality,[g] and 29th worst (out of 36) for infant mortality,[h] indicating that outcomes for newborns and infants compare unfavourably

e According to the OECD (https://www.oecd.org/en/publications/health-at-a-glance-asia-pacific-2024_51fed7e9-en/full-report/preterm-birth-and-low-birth-weight_49541696.html), "[t]his figure is based on epidemiological observations regarding the increased risk of death to the infant and serves for international comparative health statistics."

f Deaths of children within one week of birth (early neonatal deaths) plus foetal deaths of minimum gestation period or foetal weight of 1000g, per 1,000 births.

g Deaths of children under 28 days old, per 1000 live births.

h Deaths of children < 1 year old, per 1000 live births.

with those of many peer nations. Similar patterns are seen among the Commonwealth Fund comparator countries, as Canada ranked seventh worst for perinatal mortality and ninth for neonatal and infant mortality. In this group, Sweden and Norway consistently ranked best for performance, with the lowest rates of mortality (Table 3).

While mortality rates are influenced by a range of factors including geography, population characteristics, and environmental factors, the consistency of Canada's relatively poor performance across multiple indicators are cause for concern.

Policy Considerations

The challenges identified in this report are complex and influenced by a range of factors that are beyond the scope of this analysis.[i, 19] However, the findings point to several policy areas that require changes if Canada is to begin improving maternal and infant outcomes.

The first priority is increasing the availability of maternal health care providers in Canada. While Canada's relative physician scarcity is well documented, reliance on aggregate measures (i.e., total physicians per capita) has resulted in policy discussions often focusing on family doctors or increasing access to primary care. While family physicians are involved in many aspects of maternity care, data from the OECD indicates Canada actually has more family doctors per person than most of our international peers, suggesting access challenges stem from, or are compounded, by other factors.[24, 25, 26] By contrast, this study clearly demonstrates that there is a significant shortage of both OB-GYNs and midwives. These findings emphasize the importance of expanding access to providers who specialize in pregnancy, childbirth, and maternal health.

Empirical evidence from around the world supports the association between the health workforce density with many of the outcomes examined here. Research using WHO data across 191 countries found that higher densities of skilled health workers, particularly nursing and midwifery personnel, were strongly associated with better outcomes on measures like maternal mortality, infant mortality, and neonatal mortality.[27]

The international comparisons in this study also raise questions about the organization of maternity care. Canada and the US not only have the smallest maternal care workforces among the Commonwealth Fund peer countries examined, but they are also the only two in the group that primarily rely on an OB-GYN-led model of care. By contrast, every other country employs significantly more midwives per capita relative to OB-GYNs. It is unclear whether this is a medical decision by design or it is a consequence of the *Canada Health Act* primarily focusing on insurance coverage obligations for medically necessary hospital and physician services, with funding decisions for midwives left to provinces, until recently.[28, 29] There is some empirical evidence to suggest midwife-led models are associated with fewer medical interventions (such as c-sections or instrument-assisted vaginal deliveries) and potentially lower system costs, without statistically different rates of mortality.[30, 31, 32]

Readers should note that simply spending more money on health care is not the answer. Canada routinely spends more on health care than the OECD average yet continues to lag behind many peer countries on several key indicators of resource availability, utilization, access, and clinical performance.[23] Similarly, increasing the number of medical graduates alone may not be sufficient, as previous research has found "between 14% and 19% of new specialists have reported problems finding employment right after they have been certified."[33]

These findings point to broader structural challenges related to health system organization, hospital funding models, and how resources are allocated across the health sector. Part of the issue lies with hospital budgets, which do not incentivize funding specialist services (since it costs the hospital money). In particular, there may be opportunities to improve patient care by directing a greater share of health spending towards frontline services like doctors, nurses, and clinical equipment

i Including changes in the age at which mothers give birth, challenges with access to care for indigenous people, obesity rates, etc.

rather than on administrative expenditures. Readers interested in learning more about how to achieve this are encouraged to read research on activity-based funding by the author of this report and other peers in Canada.[34]

Conclusion

The data examined in this report suggests Canada faces significant challenges in maternal and newborn health. A relative shortage of key maternal care workers (OB-GYNs and midwives), combined with lengthy waits for gynaecology surgery and care, coincides with poorer outcomes for mothers and newborns than with those achieved in many comparable countries. Maternal mortality is not only higher in Canada than the OECD average, but it has also worsened over the past 20 years. And Canada continues to perform worse than peer countries like Sweden, Norway and the Netherlands on measures such as obstetric trauma, neonatal mortality, and infant mortality. While multiple factors influence these outcomes, the consistency of Canada's relatively poor performance suggests that strengthening access to maternal health services should be a priority for policymakers.

About the Author

Bacchus Barua is Research Director for SecondStreet.org. He is a Canadian economist with over 15 years of experience in the think tank world. As the former Director of Health Policy Studies at the Fraser Institute, Bacchus researched a range of key health care topics and has helped shape public discourse in the field through frequent commentary on radio and television – including appearances on CBC, Global News, CTV, BNN and articles featured in the *Wall Street Journal, National Post, Globe and Mail, Maclean's* and *Forbes*. He was also invited to provide testimony for the House of Commons Standing Committee on Health [HESA] in 2022. Bacchus currently also serves as an affiliate scholar with the Canadian Health Policy Institute [CHPI].

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