# Inequities in Canadian Perinatal Care: Indigenous Identity, Racialized Identity, Income Sufficiency and Body Size

**Policy brief based on Malhotra et al. (2024), BMC Pregnancy and Childbirth**

Canadian maternity-care quality is often evaluated through access, clinical interventions and maternal or infant outcomes. Patient experiences provide another important measure of quality: whether people are listened to, respected, involved in decisions about their care, and protected from mistreatment.

Malhotra and colleagues examined these dimensions using data from 3,280 participants in the pan-Canadian RESPCCT study. The analysis used validated patient-reported experience measures of autonomy in decision-making (MADM), respectful care (MOR), and mistreatment (MIST). Multivariable analyses simultaneously accounted for pre-pregnancy BMI, Indigenous or racialized identity, income sufficiency, education and age.

## A central finding: inequities persist after other characteristics are taken into account

Although the study was designed to examine weight-based disparities, the adjusted results reveal a broader pattern of inequity in Canadian perinatal care.

Indigenous participants experienced particularly large disparities. Compared with White non-Indigenous participants, and after accounting for BMI, income sufficiency, education and age, Indigenous participants had:

- **47% higher adjusted odds of reporting low autonomy in decision-making** (AOR 1.47);
- **35% lower adjusted odds of reporting high levels of respectful care** (AOR 0.65); and
- **more than twice the adjusted odds of reporting high levels of mistreatment** (AOR 2.26).

These findings are important because the differences remained after socioeconomic characteristics and body size were included in the statistical models. The poorer experiences reported by Indigenous participants therefore cannot be explained simply by differences in BMI, income or education within this study.

The magnitude of the mistreatment disparity is particularly striking: Indigenous participants had more than double the adjusted odds of reporting high levels of mistreatment.

The study treats Indigenous identity separately from other racialized identities, recognizing the distinctive historical and contemporary context of First Nations, Inuit and Métis Peoples in Canada, including colonial policies, displacement and continuing systemic barriers within health services. The sample was not large

enough to estimate separate effects for First Nations, Métis and Inuit participants, so important differences between Indigenous Peoples could not be examined.

## Racialized participants also reported systematically poorer care

Non-Indigenous racialized participants also experienced significant disparities after adjustment for BMI, income sufficiency, education and age.

Compared with White non-Indigenous participants, racialized participants had:

- **32% higher adjusted odds of low autonomy** (AOR 1.32);
- **28% lower adjusted odds of high respectful care** (AOR 0.72); and
- **33% higher adjusted odds of high mistreatment** (AOR 1.33).

The racialized category included Black, South Asian, East Asian, Southeast Asian, Middle Eastern, Central Asian, Latinx or Hispanic and other racialized participants. Sample sizes did not allow these populations to be analysed separately. The estimates should therefore not be interpreted as suggesting that all racialized communities have identical experiences.

Nevertheless, the consistency across all three measures—autonomy, respect and mistreatment—provides evidence that racialized identity is independently associated with how maternity care is experienced.

## Financial circumstances show a clear gradient in respectful care

Income sufficiency was independently associated with patient experience even after BMI, racialized or Indigenous identity, education and age were taken into account.

Participants were asked whether their income was **“more than enough,” “enough,” or “not enough”** to meet financial obligations.

Compared with those reporting “more than enough” income, participants reporting “enough” income had lower adjusted odds of being in the highest tier of autonomy (AOR 0.75) and respectful care (AOR 0.70). Among those reporting “not enough” income, the disparities were substantially larger: the adjusted odds fell to **0.47 for high autonomy and 0.43 for high respectful care**.

The same socioeconomic gradient appeared in mistreatment. Relative to those with “more than enough” income, people reporting “enough” income had lower odds of being in the lowest-mistreatment group (AOR 0.75), while those reporting “not enough” income had an AOR of **0.41**.

In other words, as financial circumstances became more constrained, patient-reported experiences of autonomy, respect and freedom from mistreatment became progressively poorer.

This gradient is notable because the RESPCCT analytic sample was relatively advantaged: 93% reported having enough or more than enough income to meet financial obligations and almost 70% had an undergraduate, graduate or professional degree. Socioeconomic disparities were nevertheless detectable within this comparatively financially secure and highly educated sample.

## Body size is another independent dimension of inequity

These socioeconomic and identity-related findings do not eliminate the study's central finding regarding body size.

Pre-pregnancy BMI was itself socially patterned: higher BMI was significantly associated with race/ethnicity, income insufficiency and lower education, but not with age. Participants in higher BMI categories were more likely to report insufficient income and were more frequently Indigenous or White.

Yet BMI continued to predict care experiences after race/ethnicity, income, education and age were statistically controlled.

Participants with BMI ≥35 had **45% higher adjusted odds of low autonomy** than participants in the reference BMI category. Across progressively higher BMI groups, the odds of receiving lower levels of respectful care increased. Participants with BMI ≥35 had **nearly twice the adjusted odds of high mistreatment** (AOR 1.95).

The results therefore do not support a single-factor explanation of inequitable maternity care. Body size, Indigenous identity, racialized identity and financial circumstances each contributed independently to differences in patient-reported experience.

## What this means for health policy

The findings suggest that equitable maternity care cannot be assessed solely through whether people receive services or achieve acceptable clinical outcomes. Quality measurement should also ask whether people were listened to, respected, involved in decision-making and treated without discrimination or mistreatment.

Three policy directions follow from the results.

**First, incorporate patient-reported experience into equity monitoring.** Health systems should routinely measure autonomy, respect and mistreatment and examine these outcomes by Indigenous identity, racialized identity, socioeconomic circumstances and body size. Aggregate measures of satisfaction can conceal substantial disparities between groups.

**Second, avoid treating these inequities as interchangeable.** The particularly large disparities reported by Indigenous participants warrant Indigenous-informed and culturally safe approaches that recognize the continuing effects of colonial policies and systemic barriers. Racialized populations should also be examined with sufficient sample sizes to identify differences between communities rather than combining diverse populations indefinitely into one category.

**Third, address overlapping sources of disadvantage.** Weight bias should not be considered separately from social and economic context. Higher BMI was associated with income insufficiency and other socioeconomic characteristics, while BMI, income and identity each independently predicted patient experiences. Quality-improvement strategies should therefore address weight bias alongside racialized and

Indigenous inequities and socioeconomic disadvantage rather than relying on a single universal intervention.

The findings also support greater use of weight-inclusive approaches to maternity care. Clinical decisions should be based on an individual's health circumstances and informed choice rather than assumptions derived from body size alone.

## The policy message

**Who receives care is associated with how that care is experienced.**

Even after body size, income, education and age were taken into account, Indigenous participants reported markedly less autonomy and respect and more than twice the adjusted odds of high mistreatment. Racialized participants also experienced significantly poorer outcomes across autonomy, respect and mistreatment. At the same time, a clear socioeconomic gradient was evident: progressively lower income sufficiency was associated with progressively poorer experiences of care.

These results place weight-based disparities within a wider pattern of inequities in Canadian maternity care. They reinforce the need to assess quality not only through clinical outcomes and access, but through whether people across different populations experience care as respectful, equitable and supportive of their autonomy.

**Source:** Malhotra, N., Jevitt, C. M., Stoll, K., Phillips-Beck, W., Vedam, S., & the RESPCCT Study Team. (2024). *Weight-based disparities in perinatal care: Quantitative findings of respect, autonomy, mistreatment, and body mass index in a national Canadian survey*. BMC Pregnancy and Childbirth, 24, 737.