

Midwives Responding to the Needs of Uninsured Clients: Old Order and New Immigrant Women in Midwifery Care

Sages-femmes à la rescousse des clientes sans assurance: L'ancien régime et les nouvelles immigrantes dans le contexte des soins de pratique sage-femme

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ABSTRACT

The funding structure of midwifery in Ontario enables midwives to provide care to women without provincial health care coverage. This article explores midwives' experiences in providing care to two key groups of women without provincial insurance: 1) women who lack coverage as a result of their precarious immigration status, and 2) women who opt out of publicly funded health insurance for religious reasons. Data from 15 interviews with midwives who serve these communities reveal several important themes that shape their experiences. Further, as midwives adapt their practice to work with communities of uninsured women, their goal of providing culturally competent midwifery care to more diverse groups of women becomes actualized.

KEYWORDS:

Midwifery, midwives, medically uninsured, cultural competency, social change

This article has been peer reviewed.

RÉSUMÉ

La structure de financement de la pratique sage-femme en Ontario permet aux sages-femmes de fournir des soins aux femmes qui ne sont pas couvertes par l'assurance-maladie provinciale. Le présent article porte sur l'expérience des sages-femmes en ce qui a trait à l'offre de soins à deux principaux groupes de femmes qui ne sont pas assurées : 1) les femmes qui ne sont pas assurées en raison de la précarité de leur statut d'immigrante et 2) les femmes qui choisissent de ne pas se prévaloir de l'assurance-maladie publique pour des raisons religieuses. Des données recueillies dans le cadre de 15 entrevues réalisées auprès de sages-femmes qui desservent ces groupes font ressortir d'importants thèmes qui façonnent leur expérience. En adaptant leur pratique en fonction des femmes qui ne sont pas assurées, les sages-femmes continuent de poursuivre leur objectif, soit celui de rendre la pratique sage-femme plus accessible à des groupes diversifiés de femmes.

MOTS-CLÉS :

Cet article a été évalué par des pairs.

INTRODUCTION

One of the aspirations that accompanied the push for the regulation and funding of midwifery in Ontario was the desire to meet the needs of women not necessarily well-served by prelegislation, unfunded midwifery.¹⁻³ The story often told about this era of midwifery was that care was accessed by a particular cohort of women: primarily those who were white, middle class, and well educated.⁴⁻⁶ Although there is considerable truth to this, the history is in fact more complex; while privileged women were those who predominantly accessed midwifery care, it is important not to render invisible the diversity of pre-regulation midwifery clientele. As we approach 20 years of regulated practice in the province, we are interested in how midwives experience serving a greater diversity of women. How do midwives feel about providing care to women who are often disenfranchised within the health care system? What do they find rewarding? What do they find challenging? Where are things working, and where is change needed? This article focuses on the work of midwives who provide care to women who are without health insurance.

We estimate that there are at least 130,000 people who live in Ontario without Ontario Health Insurance Plan (OHIP) coverage. This estimate is based on claims that in Ontario in 2002, there were 36,000 failed refugee claimants that were never deported and 64,000 people who had overstayed their work visas.¹² We added to these an estimated 30,000 people who were then in the three-month waiting period, calculated by dividing the number of landed immigrants in 2010 [118,114] by four, assuming that a quarter of them would be in the three-month waiting period at any time in the year. Nonetheless, 130,000 is likely an underestimate of the number of people in Ontario without OHIP coverage, as it does not include the families of refugee claimants or those overstaying visas, nor does it account for other contexts of being uninsured, such as being on a work or student visa or opting out for religious reasons. Those living in Ontario without access to provincial health coverage often work, pay

taxes, and contribute to the fabric of society in many ways; yet, for various reasons, they do not have health insurance coverage.¹³⁻¹⁵ For those with fewer economic resources, not having health insurance can be an overwhelming burden in a child-bearing year. Many recent immigrant women without access to OHIP coverage also belong to visible minority groups and may face language barriers.

Midwives in Ontario are funded to provide care to all residents of the province, regardless of whether they have health insurance.⁸ This unique provision is in contrast to their obstetrical colleagues, who must either, 1) bill through the OHIP, 2) demand payment directly from their patients, or 3) work for no payment.

In this study, we focused on midwifery care for two key communities who lack provincial health insurance. The first group is comprised of those who are ineligible for coverage under OHIP. Most heavily represented in this group are newly-arrived landed immigrants who must serve a three-month waiting period before they may access OHIP coverage.⁹ Also included are those on student or temporary work visas,¹⁰ immigrants who have lost their sponsorship,¹¹ failed refugee claimants who remain in the province,¹² and other individuals with a precarious immigration status.¹² As might be expected with people who are ineligible for health insurance, poverty and racism often emerge as central aspects of their experience in the broader health care system. Not accounted for in this list are non-immigrants who have no OHIP coverage because they lack legal documentation (i.e., those who are homeless).

The second group of people living in Ontario without health insurance are those who opt out of OHIP coverage; primarily from faith-based communities, such as Old Order Amish (OOA) and Old Order Mennonite (OOM) who are part of the larger group of Anabaptists.^{16,17} Unlike new immigrants, who tend to be concentrated in Canada's larger urban centres, OOA and OOM communities in Ontario tend to be located in rural areas.^{16,17}

The OOA and OOM are characterized by adherence

to their ancestral language (usually Pennsylvania Dutch, a German dialect); a traditional, simple, and almost always rural lifestyle; and the rejection of many products of modern technology (e.g., cars, electricity, telephones). These groups also reject most forms of government assistance, including health care.¹⁶⁻¹⁸

There are more than one million Anabaptists globally, and dozens of different communities within the tradition.¹⁸ While most of these groups blend into modern society, the OOA and OOM communities have actively resisted acculturation and are at the conservative end of the spectrum of Anabaptist groups.¹⁸ Although there is diversity within OOA and OOM groups, some commonalities help one to understand why these communities decline OHIP coverage. Central to the beliefs of both OOA and OOM groups is the idea of interdependence and the shared responsibility among community members to care for each other.^{18,19} Self-sufficiency and self-determination within the community are highly valued, and government aid is viewed as undercutting these qualities.^{17,19} Thus, although both OOA and OOM individuals pay taxes, with some exemptions, they reject nearly all forms of government aid, including child tax benefits, old age benefits, and OHIP coverage.^{16,17} It is important to note that not all those from the Amish and Mennonite communities that are cared for by midwives fit easily into the new immigrant/Old Order dichotomy posed above. While OOA and OOM communities have long existed in Canada,^{17,18} the Low-German-Speaking (LGS) Mennonites left Canada in the 1920s for Mexico and other Latin American countries, in protest against secular education.²⁰⁻²³ Members of this community have been returning to Canada since the 1970s, primarily in search of greater economic, educational, and health care opportunities. This community tends to be a very economically impoverished.²⁰⁻²³ Although there is variation among their churches, LGS Mennonites have generally embraced the use of cars and modern technologies, and they do not opt out of provincial health insurance as a group.^{20,23} Thus, for these particular Mennonites, being without OHIP coverage is the result of their newcomer status in Ontario rather than their religious convictions.

Those unable to access state-funded health care because of their immigration status and those from faith-based communities choosing not to draw on state-funded health care are in a very different position vis-à-vis access to maternity care. In this article, we explore some of the most interesting and compelling issues that emerged, through the lens of how the experience of providing midwifery care to women without OHIP coverage is both similar and different in these contexts.

METHODS

Ethical approval for this study was obtained from the Research Ethics Board of Ryerson University. Semi-structured, in-depth interviews were conducted with 15 midwives working in eight different practices. No more than two midwives from the same practice were interviewed. Interviews lasted an average of one hour. Our interview guide permitted us to respond to the experiences and ideas of the interviewees, allowing for a “reciprocal relationship between data and theory.”²⁴ Our research was intended to capture the experiences of midwives providing care to women without health care coverage.

Uninsured clients made up 30%–50% of the overall caseload of the midwives interviewed for this project. We used purposive sampling to target midwives from six urban and two rural practices. We relied on our knowledge of the midwifery community through our clinical and research work to identify practices that were known to be providing care to women without insurance. Interviews were transcribed and then analyzed with NVivo qualitative data analysis software (QSR International, Doncaster, Australia) to extract central themes from the interview data.

FINDINGS AND DISCUSSION

Providing culturally competent care in midwifery begins with the acknowledgement that uninsured women need particular attention and sometimes need to be specifically invited into care. In this study, midwives expressed a desire to find creative and thoughtful ways to ensure that care was tailored to the needs of their uninsured clients. They noted that one of the challenges for uninsured women in pregnancy was

simply gaining access to maternity care. They spoke of holding or prioritizing spots for these clients, and belonged to practices who had made a commitment to serving financially and socially marginalized women.^{11,25-27} As one midwife working in a rural practice explained, “Even if we have a waiting list, if everybody else on the waiting list has other options or has OHIP, then a person without OHIP always gets in first.”

“Extra” Work

Midwives committed extra time to ensure access and overcome barriers for their uninsured clients. The “extra” time and work associated with caring for uninsured clients looked different for the two non-OHIP communities. For instance, midwives working with new immigrants often spoke of the extra non-clinical support that accompanied their work with this population – a direct reflection of these women’s dearth of economic resources.^{11,25,27,28} Thus, some of the extra time midwives spent with uninsured clients was related to the woman’s experiences of poverty (e.g., seeking referrals to help women secure basic needs such as shelter, food, and clothing for themselves, their newborns, and other children in the family). A lack of health insurance also meant more time, 1) establishing links to community health centres and other organizations to secure funding for health care costs such as laboratory work and physician consultations, 2) undertaking negotiations with hospitals to establish preferred rates for uninsured midwifery clients, and 3) discussing the costs of various pregnancy choices with uninsured clients.

Conversely, the time commitment of midwives working with OOA and OOM communities was due to extra travel time that arose from a desire to relieve clients of the financial burden of hiring a driver to bring them into town for clinic visits. Midwives

working with these communities often adapted their care by moving most of their clinic visits (save the first and last visits) to the home setting. Several midwives spoke of having well over 50% of prenatal visits in women’s homes, and one midwife reported that she travelled an average of 40,000 km per year seeing clients in their homes. A midwife described it as follows: “We call it farm visiting; we do farm visiting [one day every week], and all the midwives from our clinic go out and do that farm visiting. So we might see as many as 20 women in a [day]. . . . We all get in our cars and start driving. . . . It’s a lot of money [for them to come to the clinic], and it is why we go out.”

In the same way that midwives caring for new immigrants identified poverty to be as significant as non-OHIP status, midwives working with OOA and OOM communities identified the rural environment to be as significant as—if not more significant than—non-OHIP status. Midwives working with OOA and OOM communities also described situations in which financial considerations drove their decisions as health care providers. One of the rural midwives explained the rationale for buying a fetal heart monitor for her clinic: “So somebody calls and says, “I don’t think my baby’s moving as much,” and you’re going to talk to them [and say,] “we think you should come in for a non-stress test . . .” And then she thinks— she sits down and thinks—“this is gonna cost \$400 [\$200 for a driver to the hospital and \$200 for the hospital fee]. For the chance that almost always

.. tomorrow the baby will move better . . .” So who’s gonna spend \$400 for that? [But] if I say, “can you come into the office? We’ll meet there and do a non-stress test.” She’s thinking, “ok, it will cost me \$50 to get the driver. Yeah, ok, no problem . . . So all of a sudden, where it was really difficult to go, to get people to go [to the hospital] . . . and we were doing a lot of home visits and like listening for half an hour and all that kind of stuff. [Now it’s better].”

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For midwives caring for OOA and OOM communities, the purchase of a fetal monitor for the clinic reduced travel time for the midwives and reduced costs for their clients. Some practices in urban settings also greatly valued having fetal heart monitors. Although the time-saving aspect was less significant for midwives working in urban centres, the cost-saving aspect for their clients was significant because uninsured clients face administrative fees with every hospital admission. While OOA and OOM clients have strong communities to draw upon to support their health care costs when needed,¹⁶⁻¹⁹ new and undocumented immigrants are significantly less likely to have a resourced and consolidated community to whom they can turn for financial support.^{25,27}

Discrimination

Advocacy for clients is central to the Ontario model of midwifery, and providing culturally competent care means midwives often act as advocates for women who may experience discrimination, prejudice, and mistreatment in the health care system. These experiences tend to differ between the two Old Order communities and the immigrant communities.

Midwives working with OOA and OOM communities indicated that their clients usually received respectful care from health care providers. They noted that both nurses and doctors working in smaller hospitals had more experience working with OOA and OOM communities, and tended to be considerate and kind. Nonetheless, they did report the occasional tendency of some health care providers to identify women from OOA and OOM based on stereotypes and assumptions about their being backwards or old-fashioned. This tendency was stronger in places where staff turnover was high, or where OOA and OOM clients make up a very small percentage of women receiving care. Midwives indicated that

these challenges arose in situations whereby women required transport to a higher-level hospital away from their usual communities. As one midwife noted, there can be “. . . lots of assumptions about. . . what they can afford, what they can't afford, what home life's going to be like with them . . . that they're all gonna have lots and lots of babies and they don't believe in birth control, and things like that, and it's just not the reality of their population. . . . Many people [in the OOA and OOM communities] are like that, but many people aren't. But they all kind of get lumped together.”

However, midwives caring for new immigrants in larger urban centres spoke of regularly observing women being mistreated as a result of their immigrant status: “We've found that in advocating, there are a lot of judgments and that's really frustrating. There's a lot of judgment about why women have no insurance, why women maybe don't have the money to pay if there's a cost involved, a lot of judgment about how those women will act towards the physicians, like they're just going to run off and not pay their bills.”

Midwives noted that in this context, women without health insurance are often seen as a “problem” for the system, and midwives may be subtly or directly blamed for bringing this problem to the hospital. The negative consequences of this kind of attitude affect both pregnant women and their midwives. One midwife spoke of the pain and challenge of “witnessing incredible mistreatment of women.”

Providing care to new immigrants, who are often poor and often women of colour,²⁸ brings to the forefront a series of myths and stereotypes sometimes grounded in a desire to protect the limited resources of the health care system, but more often grounded in xenophobic or racist assumptions about “freeloaders.” These assumptions are grounded in an insidious belief that people come from elsewhere to take advantage of

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“our” health care system, and the notion that health care in Canada is a privilege afforded to Canadians rather than a fundamental need and human right of all people. One midwife identified the often unspoken questions (“What are they doing in this country? Why did they come here?”) that underlie interactions with uninsured women in hospital settings.

Challenges and Interprofessional Collaboration in the Health Care System

Caring for women without OHIP coverage includes a great deal of nonclinical work, and often involves additional interactions with the larger health care system (and with other community supports to some degree). This is not surprising, given that midwives in Ontario work within a larger care system that presumes individuals have provincial health insurance, and is not well suited to providing care to those who do not.^{11,30,31}

For some midwives, one of the most challenging aspects of providing care for women without insurance was the complex relationships between midwives and other healthcare providers. This was expressed most often by urban midwives who work with immigrant populations. Much of the tension these midwives experienced originated from a desire to meet the needs of uninsured women while maintaining strong working relationships with their hospitals. One midwife described how her practice tried to maintain a low profile regarding their involvement with uninsured women within the hospital, despite its clear mandate to prioritize care for this community of women. Another midwife spoke of a practice that curtailed the number of uninsured women accepted into care to avoid undue stress with its hospital. “. . . We have a policy that [we] can only take in a certain number of non-insured women . . . We’re a new practice and trying to establish our reputation. . . and relationship with the hospital . . .”

It is interesting to note the contrast between the previously-cited rural practice that prioritized uninsured women and the urban practice that limited them. In the urban context, midwives have to balance the needs of uninsured clients with their professional relationships at the hospital. As one midwife explained, “And then if we do have to interact with the hospital

. . . there tends to be this “Oh, it’s another uninsured midwifery patient.” That can be seen as really negative by the hospital: “All these people never pay their bills. Why do you keep bringing them here?”

The midwifery model of care positions midwives as advocates for women under their care, which extends beyond their role as clinicians. Many clients appreciate this as they negotiate the health care system. However, midwives are placed in a position where clients may also expect them to advocate for free or subsidized care from other health care professionals in the hospital setting. Such advocacy, coupled with the fact that physicians have to ask for payment for care whereas midwives do not, can easily (and unfairly) situate physicians as the “bad guys.” In contrast, midwives are the more compassionate “good guys” in the eyes of the client, who may have no understanding of the differing funding formulas and contexts for these two groups of health care professionals. This situation is clearly flawed for physicians, and also places midwives in awkward and challenging positions with their peers.

One-on-one advocacy can be a source of conflict in interprofessional relationships whereby midwives are in the untenable position of pitting a client’s needs against those of their hospital colleagues. This conflict was much less relevant to midwives in a rural setting. When asked about this dynamic, rural midwives indicated that the OOA and OOM communities, although not wealthy, have such a strong belief in paying their own way that there would be no question of a consultant or hospital not being paid for care provided to women from these communities. Old Order clients would have access to money for medical bills from the larger church community, or (if the bills were likely to be very high, such as in the case of a baby with a significant abnormality) the community would make an exception and acquire OHIP coverage for the child. The certainty of payment facilitated smooth interactions between the midwives, consultants and hospitals. One midwife noted that it put midwives in a stronger position when they felt compelled to argue for a smaller bill for a client. She described frequently telling a new obstetrician that it was perfectly fine to bill her clients and that it would be expected. This put in her good stead, so that if she had a client who was truly destitute; she could say to the consultant, “if you

are predisposed to helping the odd client with a sliding scale fee, this would be the one.” When asked about any tension resulting from physicians’ knowledge that midwives are paid for their work with the uninsured, the midwife laughed and replied, “We don’t tell them that! I expect they think we work for eggs!” Thus, a certain level of strategic minimization is employed by the midwives, so as not to create friction in the larger health care context.

A more positive aspect of interprofessional relationships was evidenced by the collaborative relationships both rural and urban midwifery practices developed with other health organizations that work with uninsured women. In the urban setting, the most notable of these were links with local Community Health Centres (CHCs), and a number of the midwives described the work done to develop close ties with CHCs that had funds available for assisting uninsured women. When CHCs are able to pay consulting doctors for care of uninsured midwifery clients, midwives report heightened hospital relations and less interprofessional strain. For urban midwives, negotiating for client support at a structural or institutional level rather than at an individual level eased the interprofessional stresses associated with caring for women without health insurance.

Rural midwives working with OOA and OOM communities have developed working relationships with many local health care providers and collaborate to meet the specific needs of these communities. Midwives described how they had obtained and maintained privileges at numerous hospitals, each of which had something specific to offer their clients. One hospital might be more likely to permit midwives to remain as primary caregivers for clients with two prior cesarean births or with epidurals, while at another hospital it was possible for a client to have a vaginal breech delivery. Although there was an increase in administrative work for the midwives to maintain privileges at more than one hospital, this allowed midwives to “tweak” the system to the needs of clients who lacked health insurance.

One midwife noted that many OOA and OOM women will not go to a doctor unless there is severe illness. The midwives have a unique access to these communities and, with support from other health

care providers, have started to take on issues of “well-women care” that would not be considered within their scope in an urban setting. Simple initiatives such as working with a local dentist, handing out toothbrushes, and discussing dental care are ways in which midwives provide links to other health care providers. Another midwife described a unique fund jointly administered with public health to support the needs of Old Order communities. The midwives encourage clients who wish to pay for care to instead donate the money to the community fund. The money raised is used to help provide specific community care needs, such as ultrasound examinations, vitamins, translation services for those who do not speak English, or a driver for client hospital assessments. This fund has been used to help support care for LGS Mennonite women, whom the midwives describe as transient migrants, often destitute, without family support and ineligible for health insurance.^{20,21}

Motivations and Rewards

One of the most compelling themes to emerge from the interviews relates to the rewards the midwives experienced. The passion with which they spoke about the work they did with uninsured women was moving. While they openly described many of the challenges and frustrations of working in a health care system that is not suited to meeting the needs of uninsured women, most spoke with great joy and eloquence about how they found their work meaningful in terms of growth, pleasure, privilege, and reward. Midwives who were not from the same community as their uninsured clients said that they appreciated working across cultural differences, spoke of the richness that this brings to them, and expressed a deep commitment to serving women who are particularly vulnerable. One midwife described her motivation as follows: “Midwifery is immensely rewarding work, generally speaking, and of course diversity in our workplace makes work more interesting and rewarding. And for me personally, I have a pretty strong commitment to social justice and being able to provide care to people who might be in difficult circumstances or who might not be people who live with a lot privilege in their life. It’s a privilege for me to be able to provide that kind of care to people.”

Midwives also noted that the women were particularly grateful for the care they received; as a result, the midwives felt truly appreciated. One midwife explained, “Women are so thankful that you’re providing this care. They’re saying, ‘Lady, is all this really free? I don’t have to pay you anything?’ ... Just knowing how appreciative they are really makes me feel like I’ve done something really miraculous in the world.”

Some midwives stated that they enjoyed the challenge of stretching their skills, whether pushing boundaries at a home birth for a client who was hoping to avoid a large hospital bill, or simply enabling informed choice with clients who wanted to know about and reflect upon every test, often with husbands and church members weighing in. As well, midwives who worked with OOA and OOM clients experienced the pleasure of a level of continuity that few urban midwives could imagine. One midwife described, “They are usually a really fun bunch... I’ve gotten very attached to some of our families ... seeing their kids grow up...they are families that we know we are going to be involved with for a long time. Like this one woman, she is one of the Mennonites... I have delivered every one of her children but one, starting with the first one, and she’s now up to baby number eight. I just kind of think that’s really a unique continuity and longevity.”

Midwives working with Old Order communities also felt privileged to be able to practice midwifery as it was in simpler times. A midwife explained, “It’s the one little flickering flame of that old midwifery, where birth is just birth and there’s not a lot of stuff going on...you know, there’s no electricity and it’s candlelit and it’s very gentle . . . That was my ideal of midwifery when I started. I saw lots of other things that were not that, and it is really nice to know that that is still there.”

Finally, in both the rural and the urban setting, midwives talked about feeling privileged to be able to provide care to women who otherwise might not get it.

CONCLUSIONS

We began our research with the goal of better understanding how midwives experience working with uninsured clients in Ontario. The research was motivated by a desire to explore midwives’ work that

reflects midwifery’s long-standing commitment to meeting the needs of vulnerable populations. One of the goals of the regulation and funding of midwifery in Ontario is to be able to better meet the needs of a broad diversity of women. We wanted to explore the challenges and rewards of working uninsured clients in particular, and to identify the ways in which midwives integrate this work into their every day working lives.

The midwives expressed a strong commitment to provide care to women without health care coverage. They stressed that they found the work to be significant and meaningful and expressed deep satisfaction from their work. They also spoke of the extra time and effort required. The midwives noted that many of their uninsured clients lived in poverty. Limited access to funds, combined with the lack of health insurance, created many obstacles for these clients and the midwives who cared for them. For midwives working in urban areas, the fact that many clients were women of colour with varying abilities in English added further complexity to their interactions with the health care system. Midwives in the rural context described how health care colleagues did not always understand women from the OOM and OOA communities. Midwives in both rural and urban contexts expressed frustration at the continued prejudice their clients experienced from individuals who were unsympathetic to their circumstances and life choices. Ultimately, much of the work the midwives described was aimed at creating more positive and less costly interactions with the health care system. Their reaching out and accommodating women without insurance have helped to extend midwifery care to a small but significant number of women who, by virtue of being uninsured, tend to be more vulnerable vis-à-vis the provincial maternity care system. Their work, both as individual practitioners and in terms of their interactions with others in the health care system, can also be seen as helping to make the Ontario health care system more inclusive of all women in the province.

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