Meeting the Needs of Uninsured Women: Informed Choice, Choice of Birthplace and the Work of Midwives in Ontario

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This paper focuses on the work of a small group of Ontario midwives who provide care to women without health insurance. Specifically, we explore how midwives support uninsured clients as they navigate the decision over where to birth their babies. Informed choice and choice of birthplace are both core and fundamental tenants of the model of midwifery care in the province. For the small but growing number of women in midwifery care in Ontario who do not have health care coverage, the decision about where to deliver their baby is complicated by the need to consider the significant hospital bed fees which are associated with hospital birth. Our research explores how midwives navigate the complex issues which arise for women and their care providers when economic considerations enter into the decision making process with regards to birth place options. Based on interviews conducted with midwives who care for uninsured women in Ontario, the paper focuses on the provision of care in this unique context. Issues explored include; the provision of informed choice, inter-professional work, pushing boundaries and the advocacy work of midwives.

Midwives currently provide care for approximately 10% of birthing women in Ontario (Ontario Midwifery Program, 2011). Residents of Ontario are, with few exceptions, covered by provincial health insurance (Ontario Health Insurance Plan [OHIP]) which pays for most health care services, including the medical costs associated with pregnancy and birth. Although most residents of Ontario receive funded health care, a small but growing number of women every year come to midwifery care without the benefit of provincial (or other) health

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insurance (Ontario Midwifery Program, 2011). These include new immigrant and undocumented populations, women who have for various reasons lost their OHIP coverage, and women from minority religious groups who have opted out of provincial health care coverage. Thus despite a general principle of universal health coverage, not everyone residing in Ontario is in fact covered by the publicly funded health program. Those who are not are generally expected either to acquire private insurance (which is not affordable for many in this situation) or to pay out of pocket for their health care expenses.

Midwives in Ontario are uniquely positioned to be able to provide care for women without health insurance. They are able to bill the province for the care of any pregnant woman who is a resident of the province regardless of whether or not the woman is covered by health insurance (Office of the Provincial Auditor, 2000). Physicians (with a few notable exceptions) have no such arrangements with government funding bodies and therefore must negotiate directly with uninsured patients for payment.

Although midwives are able to provide their care at no direct cost to uninsured women (because midwives get paid for providing care to women who do not have provincial health care insurance) there are still considerable pregnancy related expenses for uninsured midwifery clients in Ontario. Though they do not have to pay the midwife for regular prenatal and postnatal visits, or for attending the birth, uninsured women are still usually required to pay for lab tests (including any blood work, swabs, and ultrasounds), costs for any physician consultations that may be required, as well as any pregnancy related hospital fees. The hospital “bed fee” is, for most uninsured women, the largest single cost related to their care. These fees (which can range from $500 for a 48-hour stay to $2700 for 24-hour stay in the hospitals where the midwives we spoke with held privileges) constitute a significant financial burden for uninsured women who tend to experience disadvantage in multiple ways, particularly in terms of their socio-economic status (Gagnon, 2002; Oxman-Martinez et al., 2005; Simich, Hamilton & Baya, 2006; Bernhard et al., 2007; Simich, Wu & Nerad, 2007).

Choice of birthplace is a fundamental and core principal of the midwifery model of care in Ontario and is a topic of ongoing debate and dialogue within the different contexts related to maternity and newborn care. Debates over the safety and desirability of home versus hospital birth continue to garner attention, both in academic (Boucher et al., 2009, Cheyne, 2008; Craven, 2005; Hutton, Reitsma & Kaufman, 2009; Janssen et al., 2009; Johnson & Daviss, 2005; Vedam, 2003) and more popular contexts. Our paper focuses on how midwives work to support women without health insurance as they navigate the complex decision over
whether to birth their babies in the hospital or in an out-of-hospital setting (usually home), often in confined financial circumstances. This discussion contributes to the expanding knowledge both about processes of informed choice and about choice of birthplace. Our focus on midwives caring for the uninsured in Ontario provides a contribution to scholarly knowledge by exploring a topic that has yet to be examined in scholarly discussions of health care provision in Canada. Our work tells the stories of midwives who have a unique and particular role vis-à-vis informed choice and choice of birthplace for women in Ontario. It makes visible the very meaningful work of a small group of health care providers attempting to meet the needs of women from more marginalized groups.

We engage in this work from a feminist social justice perspective. As researchers we are interested in health care provision to those who are often marginalized within the health care system. We are curious about the ways particular health care practices might serve to foster rather than diminish choice, and agency for those women who might otherwise experience less control in health care situations. We explore the particular ways in which midwives, as front-line health care workers, provide care to uninsured women that can be seen as unsettling and challenging rather than reinforcing experiences of exclusion and marginalization in the health care context.

LITERATURE REVIEW: UNINSURED MIDWIFERY CLIENTELE

We estimate that there are roughly 130,000 people presently living in Ontario without health care coverage (Association of Ontario Midwifes, 2009; Bennett & Burton, 2012; Citizenship and Immigration Canada, 2010; Right to Healthcare Coalition, 2011). As we have noted elsewhere, uninsured women who seek out midwifery care cannot be seen as a homogenous group (Bennett and Burton, 2012). There is considerable diversity in both the reasons behind their lack of health insurance coverage and also in their general living circumstances.

Although each woman’s story is unique, the reasons why women under midwifery care lack health coverage can be grouped in a few broad categories. Some women are without access to coverage because they lack legal status in Canada. This includes immigrants who have lost their sponsorship, failed refugee claimants, individuals who have expired student or work visas, and women who entered Ontario to live and work without ever having had any official status in the country. Women without legal status in Canada have no access to publicly-funded provincial health insurance plans. A second reason that women in midwifery care may not have access to OHIP is that they are landed immigrants who are in their three-month waiting period. The ‘three
month waiting period’ is a provincial residency requirement which must be met before new immigrants can receive provincial health care in Ontario (Ministry of Health and Long-Term Care, 2009a). Some uninsured women are technically eligible for OHIP, but have, for various reasons, lost their coverage. This group of women includes homeless women and women in transient housing who may have challenges with health coverage card renewal and retention, and Canadian born women of precarious immigration status parents who may be unaware of their rights to health coverage. Finally, although not specifically addressed in the context of this paper, a significant group of women without health coverage who access midwifery care are those who are living in orthodox religious communities who opt out of provincial health insurance coverage due to religious and cultural beliefs. In Ontario these groups include Old Order Mennonite and Old Order Amish communities (Bennet & Burton, 2012, Gingerich, 1972; Peters, 2003; Gingrich & Lightman, 2006).

It is difficult to obtain aggregate socio demographic data on women who do not have health insurance in Ontario because the very same reasons which contribute to their lack of health insurance make them less likely to be represented in statistical databases. Women who lack status or have precarious status in Canada, who have unstable housing, and who experience language barriers, are all difficult to gather data about. Nonetheless, we do have access to health related research which provides some information about the demographics of the uninsured women seeking maternity care. This research suggests that uninsured women are more likely to come to maternity care late in their pregnancy, they are more likely to be of lower socioeconomic status, experience language and cultural barriers to accessing health care and are at higher risk for poor prenatal outcomes because of these circumstances (Bernhard et al., 2007; Bollini et al., 2009; Caulford & Vali, 2006; Harris, Humphries & Nabb, 2006; Rousseau et al., 2008). Although there is a small minority of uninsured midwifery clients in the province who, due to financial or other status, are in relatively privileged positions, the majority of women in Ontario without health insurance tend to be less resourced. Despite the considerable diversity of contexts in which women without health insurance live (Gagnon, 2002; Goldring, Bernstein & Bernard, 2009), for those with fewer economic resources, not having health insurance during a childbearing year is likely experienced as an overwhelming burden (Bernhard et al., 2007).

Pregnant women without health care coverage arrive to midwifery care in a number of ways. Some are referred to midwives from other health care providers such as Community Health Centre (CHC) workers and other social service agencies who are aware that midwives will not charge women for care. Some women come on
recommendations from friends or family who have used midwives. Others learn through word of mouth, or the internet, that midwifery care is funded for those without health insurance. Some may have learned about midwifery care through the outreach efforts of midwifery practices that seek to provide care to this community.

On Birthing at Home

Women choose to birth at home for a wide variety of reasons (Boucher et al., 2009). Within the context of midwifery care, reasons for choosing homebirth are commonly understood to be grounded in a philosophy or belief about the kind of birth women want (for example a more ‘natural’ or less medicalized birth). We are interested in the provision of care to women who are birthing at home at least in part out of a sense of necessity; out of the need to avoid the often-prohibitive costs of a hospital stay, rather than exclusively for ideological reasons or for reasons of wanting a particular kind of birth. For many uninsured women (as for many others) home may not be seen as the most comfortable or safe place to birth (James, 1993). Many newcomers share accommodations with other family members, acquaintances, or friends (Statistics Canada, 2005), and birth in crowded and public conditions can be experienced as uncomfortable or awkward. Furthermore, ‘natural’ childbirth is not the goal for all women; the limited availability of medications to relieve the pains of labour at home may add to the lack of desire to birth in this setting, and the belief that the hospital is a safer or more desirable birthing environment may be a more meaningful lens for many new immigrants, especially those coming from less resourced countries where homebirth is more likely to be a marker of poverty than ideological conviction.

Choices are always made within lived contexts and the midwives we spoke with acknowledged the complexity of this as they reflected on the diverse ways uninsured women worked to make the birthplace decision that was best for them. Despite the tendency to assume that women without health insurance may in some sense have ‘less choice’ about where to birth, the midwives we interviewed highlighted the ways in which uninsured women are most often acting with considerable agency in complex circumstances. The aim of this study was to explore the work of midwives as they support uninsured women’s decision-making process in a context where economic circumstance had a significant impact on their birthplace decision.

METHODOLOGY

In 2010 and 2011 we interviewed sixteen Ontario midwives about their experiences of providing care to women not covered by provincial
(or other) health insurance. Both researchers are well acquainted with the small midwifery community in Ontario. One is a university midwifery educator, and the other is both a practicing midwife and midwifery educator. We started our participant search by identifying those Ontario midwives whom we knew to be caring for significant numbers of uninsured clients. We used purposive sampling to capture the experience of midwives in practices for whom providing care to women without health care coverage had emerged, either intentionally or accidentally, as a significant part of their work.

The midwives interviewed for this study reported that, on average, 10-30% of their clientele had no access to health care insurance. We made efforts to interview midwives working in a variety of contexts including those who practice in urban centres, those working in suburban areas and a number of midwives working in rural Ontario. We spoke with midwives in more established as well as newer practices, and with a mix of more experienced and newer practitioners. The midwives we interviewed all worked in independent group practices alongside other midwives. Ethics approval for this study was obtained from the Research Ethics Board of Ryerson University. We were not gathering primary health data; nor were we interviewing recipients of midwifery care, therefore no other ethics approval was required for our research. Midwives were approached through a personal e-mail request for participation in our study, and all of the sixteen midwives agreed to be interviewed.

The embeddedness of both authors in the Ontario midwifery community meant that all interviewees were known to one or both of us. Therefore meticulous attention was paid to confidentiality throughout the research process.

We conducted semi-structured, in-depth, individual interviews. Questions, designed collaboratively by both authors, were open-ended and were intended to capture the experiences of midwives supporting uninsured women who were making birth location decisions. An interview guide was created and adhered to. In addition, we also ‘followed’ the direction that our interviewees took, allowing their experiences to guide further questioning. The interviews were all conducted in-person by both researchers. Interviews took place either in the interviewees’ clinical practice sites or at Ryerson University in Toronto. Interviews lasted on average one hour.

Each of the interviews was audio-recorded, and was later transcribed and then coded using NVivo qualitative data analysis software (QSR International, Doncaster, Australia). Content analysis permitted the identification of recurrent themes from the interview data. Analysis resulted in the choice of four key areas for discussion in this paper: informed choice, interprofessional issues, advocacy and pushing
FINDINGS & DISCUSSION

Informed Choice

Our interviews revealed a consistency of approach regarding informed choice discussions for uninsured clients. Every midwife we spoke with stressed that they are careful to discuss all the same things with their uninsured clients as they would with other women, with one notable and consistent exception. Each midwife we spoke with said that for uninsured clients they would also include a detailed discussion of the financial costs associated with care in hospital versus care out of hospital.

Midwives had a number of different strategies to manage the tension that they perceived between the ideal of informed choice regarding choice of birthplace, and the realities of decision making for this particular community of women in their care. One midwife indicated that when she talked to uninsured women she would “try to step back and pretend that the woman had money” to pay for the hospital birth (even if she knew she did not) “and present it that way and then talk about the money only after.” Other midwives stressed the consistency in terms of the discussion that they would have with an uninsured client versus any other client:

I would say generally there is no difference, there’s a full discussion of the risks and benefits. We try to talk to everybody about it, planned hospital, planned home, non-OHIP, whatever, so that people have an understanding of the risks, limitations, benefits, and advantages of the different choices so that they are in the position to make a choice whenever they need to.

Although all the midwives we spoke with described a similar adaption of their informed choice discussions about birthplace for their uninsured clients, the way they felt about women choosing to birth at home for financial reasons showed less uniformity. Some expressed that the cost associated with a hospital birth was just one of the many factors
that a woman would consider in her decision-making process. For others, issues of financial influence on choice of birthplace were seen as more problematic. Some midwives identified that when women chose to birth out of hospital for financial reasons, it sometimes resulted in the midwife feeling less secure in the decision the woman had made:

_"I feel like women should have access to the place where they feel the most safe and I do feel that the progress of labour does depend on a woman's comfort level and I feel pretty strongly that if women really are feeling that they should be having a hospital birth but they're choosing to have an out of hospital birth, that their labour may slow down. Not always, but that they're putting themselves in a situation where they don't feel as safe, that's tricky for me. It wouldn't be the way that I would want people to make decisions."_

The fact that many uninsured women are also not fluent English speakers can add yet another layer to the complexities of providing informed choice around birthplace and more generally in their everyday lives (Gagnon, 2002; et al., Guruge et al., 2009; Statistics Canada, 2005). Midwives noted that it was not always clear how much women understood as they worked across various language barriers. It was identified as less-than-ideal that these discussions were often conducted with the aid of non-professional translators (usually husbands and other family members). "I know we're not supposed to rely on family," commented one of the midwives, "but when we don't have funds for translation and they don't have a translator what can you do?" While some midwives questioned whether family members were able to accurately relay the information about choice of birthplace to the women in care, others questioned who in a family was making the decision about choice of birthplace. These midwives sensed that women sometimes felt immense pressure from family members to stay at home for financial reasons.

That midwives had conflicted feelings about women choosing homebirth for cost saving reasons is not surprising given the history and context of both homebirth and informed choice in Ontario. Both of these concepts emerged as core themes in North American movements for childbirth reform of the 1970s, movements which lead to the eventual regulation, integration and funding of midwifery in Ontario in 1994 (Ministry of Health and Long-Term Care, 2009b). In the pre-legislation era midwifery grew almost exclusively in the out-of-hospital context, and choice of birthplace was enshrined as one of the three core principles (along with informed choice and continuity of care) of the midwifery model of care in Ontario.
Although close to 80% of midwifery clients in the province today opt to birth in hospital (Ontario Midwifery Program, 2011), homebirth is discussed with every client as an option. Homebirth continues to be seen by many in midwifery circles as an emancipatory choice; imagined not as a site of oppression and containment for women but as the ideal place where women can labour and give birth with minimal intervention, (Bourgeault, 2006; MacDonald & Bourgeault, 2009) on their own terms, in their own space. This perspective, which is situated in the history of the North American alternative birth and homebirth movements, is not of course, shared by all contemporary midwifery clients. A significant percentage of uninsured midwifery clients are newcomers to Canada, many coming from countries with inadequate reproductive health resources (Gagnon, 2002). While the safety of planned homebirth has been well established in research studies (Olsen, 1997; Johnson & Daviss, 2005; Hutton, Reitsma & Kaufman, 2009; Janssen et al., 2009), in many places around the world homebirths are unattended by trained personnel, making them substantially less safe than hospital birth (World Health Organization, 2011). For women from such milieux, homebirth may be interpreted as second-class care or even as a denial of basic human rights. Seen from this perspective the ‘bed fees’ charged by hospitals can be viewed as a mechanism through which a small sub group of residents, women who are mostly newcomers, mostly women of colour, and mostly poor, are denied the standard of care that the rest of the community enjoys. Our discussions with midwives revealed a significant tension between home as an imagined emancipatory place for birth and home understood as ‘second class’ care. Midwives caring for the uninsured can thus be challenged to provide quality care to women whose lived realities do not necessarily fit easily into traditional midwifery norms and assumptions.

Interprofessional Issues
Providing care and choice of birthplace to uninsured women impacted the interprofessional working world of midwives in a variety of ways. The complex set of relationships between midwives and other providers emerged as one of the most challenging aspects of the work of caring for those without insurance. Much of this tension stemmed from midwives wanting to meet the needs of this community of uninsured women, and of also needing to maintain strong working relationships with the hospitals where they provide care. Midwives described different strategies for coping with hospital relations in a context where uninsured women are often seen as a ‘problem.’ In some cases midwifery clinics worked to maintain a low profile vis-à-vis this work within the hospital, despite the fact that they might be seeking to meet the needs of uninsured women in particular. In one case a practice
actually curtailed the number of uninsured women they provided care to so as not to cause undue stress with the hospital, despite the fact that the practice had been established in part to meet the needs of this community:

...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 ...

Even amongst the small cohort in this study, the range of experiences with obstetrical colleagues in relation to this issue was striking. At times, interprofessional relationships were clearly strengthened as physicians became aware that midwives could care for uninsured women and get paid for doing so. These physicians viewed this aspect of midwifery work positively and fostered collaborative relationships with midwives on this basis:

At one smaller community hospital, they’ve been great. (...) There have been a couple of OBs who have specifically said, “If you need something, let me see what I can do.” And they’ve seen clients for low cost or no cost for repeated visits. They’ve participated in consultations, where it’s within midwifery scope but we’ve needed their opinion...

In some other contexts, midwives have had to work hard to convince medical colleagues about the advantages of midwives providing care to uninsured women. This often requires considerable time on the part of midwives:

We had to do a lot of meetings saying to them ... “if we’re not looking after them, they will show up at your [emergency department] when they are in labour.” By far the largest [percentage] of them had no contact with the hospital whatsoever. They had their babies here [in the midwifery clinic] or at home, they didn’t have any consults ...

As this midwife describes, time and effort on the part of the midwives to communicate a better understanding of the care they provide to women and the overall low impact on the system that results from this care has led to more positive relations with their privileging hospital. Thus, in some contexts, the sense of midwives providing a service that helps, rather than hinders the hospital was understood.

Reflecting on both the practicalities and complexities of providing care to uninsured women, the strains this can sometimes place on
relationships between midwives and physicians are perhaps not surprising. Assumptions, for example, about uninsured women’s ability to pay out of pocket for hospital costs can create tension between hospital staff and the midwives who ‘bring them’ to the hospital for care:

*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?’*

Sometimes, the inability of some women to pay their hospital bills clearly damages midwives relationship with their privileging hospitals:

*There have been a couple of situations where [a client] is only able to pay a partial bill, or takes a really long time to pay their bill, or is clearly not planning on staying in the country… And so they’ve threatened our privileges, they’ve threatened our reputation at the hospital …*

Most physicians in Ontario are paid fee-for-service through OHIP, which provides health coverage for most Ontario residents. As explored in previous research (Bennett & Burton, 2012), this means that when women without an OHIP health card present in the hospital needing care, physicians are put in the position of either not being paid for their work, or needing to ask the woman and her family for payment. As midwives do not have to charge uninsured clients in order to be paid for care services, it can easily, and unfairly, situate physicians as the ‘cold hearted bad guys’ in contrast to midwives as ‘compassionate good guys’ in the eyes of the client, who may well have no particular understanding of the differing funding formulas and contexts for these two health care professionals. While this situation is clearly flawed for physicians, it also places midwives in an awkward and challenging position.

The midwifery model of care positions midwives as advocates for the women they care for, a role that extends beyond their tasks as clinicians and caregivers. Many clients truly appreciate this role as midwives act on their behalf as they negotiate the health care system. However, in this particular situation, midwives are placed in a position where clients may expect midwives to also advocate for free or subsidized care from other health care professionals working in the hospital setting. This type of one-on-one advocacy can serve as a source of conflict in interprofessional relationships, placing midwives in the untenable position of pitting a client’s needs against those of her colleagues in the hospital.
Both this study and earlier research (Bennett & Burton, 2012) revealed a more positive aspect of interprofessional relationships that was evidenced in the meaningful relationships that some practices have developed with their local CHCs. A number of the midwives interviewed described working to develop close ties with CHCs that were then able to assist midwifery clients with lab and consultation fees. Where CHCs are able to pay consulting doctors for the care that they provide to uninsured midwifery clients, midwives report less interprofessional strain and heightened hospital relations. Negotiating with local CHCs for access to funds to cover lab tests and ultrasounds, and with privileging hospitals for subsidized or free hospital stays represented significant extra-clinical labour for midwives working with uninsured women. This negotiating work was seen as valuable institutional work by midwives who preferred this to one-on-one negotiations with other health care providers done in the individual moment of coming in for a lab test, consultation, or a birth.

In the absence of prearranged funding agreements for their clients, uninsured women are required to pay out of pocket for any care they receive from physicians. Some uninsured clients never repay the physicians for their work (Ontario Medical Association, 2011) and in fact may well be simply unable to do so (Berinstein et al., 2006). Midwives in this study articulated that they are thus often identified as bringing a ‘problem’ (uninsured women) into the hospital. Midwives’ experiences here reveal what is essentially a broader social and political problem; that of the gap between the principal and the reality of ‘universal’ health care coverage that is highlighted when those without OHIP require health care services. Although midwives may be supported (i.e. paid) to provide care to those without insurance, obstetricians and other care providers are left in the challenging and awkward position of having to respond at an individual level to this system-wide gap in services. At the core of these issues is the fact that midwives and their obstetrical colleagues work within a system that is neither designed nor coordinated to provide care for uninsured women (Oxman-Martínez et al., 2005; Bernhard et al., 2007; Asanin & Wilson, 2008; Miedema, Hamilton & Easley, 2008). The challenges and struggles that result are often lived out in the highly individual working relationships of particular care providers, rather than at the system-wide level, which is more accurately where they belong.

Advocacy

Much of the advocacy work that midwives described doing for uninsured clients was non-clinical in nature, and a significant amount of this reflected the fact that women without insurance tend to have fewer economic resources (Magalhaes, Carrasco & Gastaldo, 2009). Thus many
of the things that midwives in this study did to assist uninsured clients centred around mitigating or alleviating the often overwhelming experiences of poverty. Examples include seeking out referrals to help women secure basic needs such as shelter, and to obtain food and clothing for themselves, their newborns, and other children in the family. Midwives also described working to maintain a database of organizations in their catchment areas to which they could refer women for various non-clinical needs.

The advocacy work that was described as most intense and stressful for midwives was that which took place on the labour floors. Advocacy might involve a discussion with an obstetrician or others on the obstetrical team in the middle of the night to try to negotiate a lower consultation fee if there was a need for interventions beyond the scope of midwifery care. Midwives expressed discomfort about having to ask another health care provider to work for less than their normal pay, or to work for free. Yet at the same time they felt compelled to advocate for their clients:

*It’s very challenging when you’re caring for someone who doesn’t have OHIP, particularly if you know that they don’t have money either, and something complicated starts to arise. You know, it’s a real challenge; I don’t feel great about asking my medical colleagues to work for nothing.*

In one hospital, a midwife explained that their CHC had a policy of only paying for epidurals that were medically necessary. Midwives would thus advocate on the behalf of uninsured women who were asking for pain relief and part of the advocacy included the need to clearly document when medical necessity was present so that the woman would be spared the costs of the epidural procedure.

The stress experienced by midwives was more acute in situations when uninsured woman had planned a homebirth and had to transfer into hospital. Midwives described having to manage the attitudes of others in the health care system who were unsympathetic to the realities women faced when their plans to birth at home did not work out. A number of the privileging hospitals where the midwives worked had non-refundable registration fees for uninsured women. In these hospitals, all pregnant women were expected to pre-register prior to the birth and those without OHIP were expected to pay the pre-registration fee along with either a down payment or the full price for a 24-hour stay. The fact that the registration fee was non-refundable was seen as a disincentive to register at the hospital for uninsured women planning to birth at home, and midwives point out that as a result, many women chose not to do so. While this seemed a reasonable approach to the
midwives, it was not always perceived that way by other hospital staff. Midwives told us that when women did not pre-register, they were seen as “financially irresponsible,” rather than as someone who was making a reasonable choice in a challenging situation. “People can be quite vindictive,” one midwife lamented with regards to the pre-registration issue. The same midwife reported witnessing anesthesiologists and other doctors refusing to provide care until they were presented with cash or telling the midwives to simply “take the woman to another hospital.” As this midwife explained:

> 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 also spoke of the background work that they had done in advocating directly with the financial departments at their privileging hospital for lower hospital fees, securing support and ultimately special financial arrangements for women without OHIP. One practice gathered data on their typical length of hospital stays, noting that midwifery clients often labour at home and leave the hospital early, so as to provide a detailed rationale (based on their overall light use of hospital resources) for why their uninsured clients should receive a reduced fee to birth in hospital. Like the work that midwives engage in to establish relationships with CHCs, this activity makes up part of the extra non-clinical work that midwives do as they seek to provide good care for women without insurance.

The time put into this type of advocacy work was valued by the midwives not only because it eased financial burdens on pregnant and birthing women, but also because it lessened the interprofessional strains that often occurred when midwives had to advocate in the moment, one-on-one with other members of the health care team. Predetermined, consistent fees and protocols created through system-level advocacy work were identified by midwives as one way to lessen the need for ‘in the moment’ advocacy and thereby as a means to minimize interprofessional conflict.

**Pushing Boundaries**

In attending homebirths with uninsured women, midwives described the experience of working outside of their comfort zone, their familiar zone, or sometimes simply their ‘usual’ zone. Most midwives reported attending homebirths with uninsured women that seemed to
have been chosen more out of economic necessity than out of any strong or proactive desire to birth at home, and for most, this was not particularly problematic because they considered economic necessity as reasonable a factor as many others to consider when choosing where to birth. Few were willing to create a distinction between home birth for ‘good’ reasons and home birth for ‘bad’ reasons:

*From my perspective... there aren’t better and ‘worse’ reasons [to choose homebirth]. I might have opinions about it, but the whole point of informed choice is it’s an ‘informed’ choice, so if those people determine that, on balance, even though if they had the money they’d go [to the hospital] but they don’t have the money so they’re not going to go, why is that any more or less legitimate a choice than ‘I don’t want to go to the hospital because someone I love died there,’ or ‘I don’t want to get in the car because it’s uncomfortable?’*

Sometimes midwives spoke of a tendency to practice more conservatively in this context, the opposite of pushing boundaries. This accommodation may best be explained as a response to the midwife’s sense that the birthing woman was staying at home more out of circumstance than belief:

*And that does make me feel a little more uncomfortable, a little more on edge. I think it does make me feel more cautious in terms of their care. I don’t know this for sure, but I think it makes me possibly a little more conservative because I particularly don’t want to go into the hospital with a woman who has very significant complications in her labour and doesn’t have money. Pushing the boundaries with someone who doesn’t have that financial [backup], it becomes really tricky... I try not to let that influence my clinical management, but I am aware that it sometimes plays into it.*

Another midwife discussed a similar tendency in her work with uninsured clients:

*I might practice a little more conservatively in that context, and that’s really more a response to their risk aversion rather than to their OHIP status. Like if someone is, with a small amount of reluctance, planning a homebirth, you’re not going to push any boundaries, if you know what I mean.*
Not infrequently, however, midwives spoke of the uncertainty of being in homebirth settings and having to think differently about when to transfer and how far to push boundaries. As some midwives noted, attending a homebirth with an uninsured woman came with a different type of awareness of risk:

“I call it ‘pushing your plate’ or pushing your skills a little bit...sometimes you go into these situations and you have a medical or obstetrical concern and you really feel that the preference would be to have a hospital birth, but they can’t afford it. You can’t just say, ‘no, you can’t be in our care, we’re going to discharge you from our care,’ because then you’re putting them in a situation where they’re just turning up in the hospital and they are not going to get the best care. So I definitely push it and try as best I can to see that she has a straightforward birth…

Similarly, this midwife acknowledges the difficulty in balancing her client’s financial needs with her own comfort zone as a practitioner:

I think I do recognize that I feel sometimes a bit more on edge, that there may be repercussions for me as a practitioner if there’s a negative outcome, either by the hospital or by the client… So if there’s a situation where I can avoid calling an ambulance for transport, I will, and that does play in and around pushing the boundaries.

The above quote provides a good example of the give and take many midwives articulated in attending uninsured women at home; at one and the same time more cautious about repercussions of actions, while at the same time stretching their skills as far as they would go to honour the desires or the need of women to stay at home. These tendencies to practice more conservatively on the one hand, or to push boundaries a little further in the context of a homebirth for financial reasons is one of the most challenging and complex themes that emerged from this study. Throughout our interviews we found midwives speaking honestly and with tremendous courage, revealing their vulnerability as they grapple with the fact that their practice will vary and respond to the context of a birthing mother in ways that are often not supposed to be acknowledged in medical or health care contexts. In doing so, they bravely reflect on the very human fact that clinical judgment is not pure, nor beyond social and cultural context.
This paper provides discussion of the work of midwives in Ontario who provide care to women from a specific marginalized community. Our research provides insight into the complex ways in which midwives organize care to maximize options for women without the benefit of health insurance, all the while working in the context of a health care system that fails in multiple ways to meet the needs of this diverse community of women. Although grounded in the specific context of both midwifery practice in Ontario, as well as state-funded health care, this study contributes to understandings of both informed choice and choice of birthplace in broader contexts.

The midwives we spoke with reflected a deep commitment to maximize informed choice regarding choice of birthplace for their uninsured clients. Midwives described working with community agencies and lobbying privileging hospitals to try to secure reduced costs for care not associated with their own services. They took time to describe costs associated with different birthing options ahead of time for clients as part of their informed choice discussions. They advocated for clients by working for structural changes and when necessary would advocate one-on-one with other hospital staff in an attempt to help negotiate for lower fees. They considered the woman’s needs and wishes in context when making difficult management decisions regarding possible transport into hospital from planned home births, at times pushing their own boundaries in the hopes of providing care that was both safe and respectful of the choices of their clients.

While the midwives in our study described facing many additional challenges in providing care for this population, they almost uniformly identified the fact that this work was not without rewards. Many midwives had much to say about the pleasures of working with this community of women. Most spoke eloquently about how meaningful this work was to them, and the feelings of growth, pleasure, privilege and reward they received for providing this care:

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.
The work of midwives as they strive to best support uninsured clients has revealed a wealth of strategies that serve to mitigate the often profound limitations of the health care system in caring for this community. In the absence of being able to remove the causes of lack of truly universal coverage for all people in Ontario, the recommendation that emerges from this research is for sustained and enhanced support to those in the health care system who are working to provide care to the uninsured within the confines of a system not designed to meet their needs. Efforts towards serving uninsured people in Ontario will be best served when systemic supports are in place, through the organizing bodies of health care providers (such as the Association of Ontario Midwives) which will in turn support individual health care providers to promote women’s agency and choice. This should not be the ‘extra’ work of midwifery, but rather the standard and daily work of all health care providers. These efforts are well under way within the health care and activist communities in Ontario, through lobbying to end the three-month residency requirement which restricts access to health care to new immigrants, through coalition work amongst health care providers to expand rather than retract health care coverage in the province, and through efforts to create systems to support providers in caring for the uninsured. We lend our voices to these efforts, and hope to have highlighted the often tremendously moving, successful and valuable work of a small community of health care providers who are on the front lines of making change within the health care system.
REFERENCES


