**HRTO FILE 2013-16149-I**

**HUMAN RIGHTS TRIBUNAL OF ONTARIO**

**ASSOCIATION OF ONTARIO MIDWIVES**

**Applicants**

**v.**

**HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO AS REPRESENTED BY THE MINISTER OF HEALTH AND LONG-TERM CARE**

**Respondent**

# AFFIDAVIT OF MADELEINE CLIN

I, Madeleine Clin of the Township of Mapleton, in the Province of Ontario, MAKE OATH AND AFFIRM as follows:

1. I am a registered midwife in the Province of Ontario. I have been engaged in the clinical practice of midwifery for 27 years. Over that time, my practice has been almost exclusively in rural areas. I have been active with the AOM as the Chair of the AOM's Rural and Remote Midwives Working Group from 2007 to 2014. During the same seven years I sat on the AOM's Board of Directors as a regional representative. I have also been an active member of the AOM negotiations' teams. I am also a complainant in this proceeding.

2. My background, knowledge and experience which support the statements in this Affidavit are set out in my Curriculum Vitae[1] and summarized in Part 1 below. This affidavit constitutes the main section of my examination in chief in this proceeding.

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1 Curriculum Vitae of Madeleine Clin, AOM0016602.

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## I. BACKGROUND

### 1. Education, Apprenticeships and Training

3. In 1981, in the absence of an accredited midwifery education program, I entered the Independent Studies program at the University of Waterloo where I worked with faculty to design a midwifery program. This was completed in 1993 (after a significant break for motherhood, nursing school and a midwifery apprenticeship) when I obtained a Bachelor of Independent Studies (Midwifery) from the University of Waterloo.

4. I completed a Midwifery Apprenticeship in 1990. I was apprenticed with Elsie Cressman, Heather Burton and May Toth, experienced midwives in Kitchener, Mississauga and Hamilton, respectively.

5. In 1989, I also obtained my Registered Nursing Diploma from Mohawk College.

6. In the early 1990s I began developing a focus on maternal care, taking post-graduate nursing certificates in High Risk Obstetrics, High Risk Neonatology and Breastfeeding.

7. In 1997, I completed my Prior Learning Education and Assessment Program of the College of Midwives of Ontario. The PLEA Program accepted my previous education and experience as equivalent to the MEP. I became a registered in March, 1997.

**2. Practicing Midwife and Registered Nurse**

8. I began my health care career as a pre-regulation midwife, beginning my practice in 1990 after completing my apprenticeship. I worked in Hamilton, Kitchener and the rural area west of Kitchener.

9. After regulation in January, 1994 I was no longer able to work as a midwife. As a result, I worked as a Midwifery Second Attendant at Countryside Midwifery Services from 1993-1997.

10. While I was working as a Midwifery Second Attendant, I worked as a Registered Nurse from 1990 to 1997. I worked first at the Henderson General Hospital, the Hamilton General Hospital, and then at the Guelph General Hospital. I was a RN at Henderson and Hamilton General Hospitals from 1990-1992. From 1994-96 I worked at Guelph General Hospital.

11. In 1997, when I completed the Prior Learning Education and Assessment Program, I began to practice as a Registered Midwife. I completed my New Registrant's year from 1997 to 1998 at the Huron Community Midwifery Services. I started at three quarters of the level 1 pay grade for the first 6 months as I was not an MEP graduate.

12. In 1998, I returned to practice as a registered Midwife at Countryside Midwifery Services with privileges at Grand River Hospital and Seaforth Hospital.

13. I subsequently obtained privileges at two other hospitals: the Palmerston District Hospital (2002) and Stratford General Hospital (1999). Each one required me to be on a committee. Palmerston is level 1 hospital, which means that they do not do epidurals, inductions, or emergency caesarians. At Palmerston, we only took clients who were candidates for a home birth. For anything with the potential for greater risk, we would take to Stratford, a level 2 hospital.

14. I became the Head Midwife at the Stratford General Hospital in 1999. Stratford Hospital limits the scope of midwives. Even though the CMO allows midwives to retain care in consultation, Stratford requires a transfer of care if it is necessary to administer oxytocin or do external cephalic version or a breech birth. As well,

Stratford obstetricians decided that we had to do a consultation whenever there was a VBAC client – i.e. a vaginal birth after caesarian. Such consultation is not required by the College of Midwives. At Stratford, it was only 3 years ago when they no longer required a transfer of care with an epidural. Obstetricians all unilaterally decided these practices. Obstetricians are able to bill for work they do not share with midwives when they mandate unnecessary transfers of care.

15. The relationship between midwives and obstetricians at Stratford is generally a good one, but very hierarchical. It took until after 2005 for a midwife to be permitted to join the Medical Advisory Committee. This hierarchy and the unnecessary restrictions did have an impact on the trust relationship between physicians and midwives.

16. Starting in 1998, I worked with the Perth District Public Health Unit with their Health Breast Feeding Coalition and Healthy Start program. Members of my practice continue this work to this day.

**3. Academic and Clinical Teaching**

17. I am a Clinical Preceptor in the Ontario Midwifery Education Program.

18. I have been a Clinical Adjunct Professor at the McMaster University Faculty of Medicine since 2011.

19. I have been a conference presenter on a variety of topics including on rural midwifery as set in my Curriculum Vitae.

**4. AOM/CAM Roles**

20. I have been active with the AOM as the Chair of the AOM's Rural and Remote Midwives Working Group from 2007 to 2014. During the same seven years I sat on the AOM's Board of Directors as a regional representative.

21. I have also been active in the realm of negotiations. I was on the AOM negotiations committee from 2007 to 2008. I rejoined the negotiations team from 2010 to 2011.

22. I served as the secretary of the AOM's Board of Directors from 2013 to 2015.

**5. Inter Professional Collaboration and Midwifery Integration**

23. As highlighted above, my professional career has involved extensive inter professional collaboration with maternal and newborn health professionals, particularly physicians and nurse practitioners and including my work as a Head Midwife at Stratford General Hospital.

24. As a midwife who trained and practiced as a Registered Nurse for many years, I have unique insight into the inter-professional dynamics of midwives, nurses, and physicians.

## II. EXPERIENCES OF STEREOTYPING, PREJUDICES AND HOSTILITY

### 1. Introduction

25. I experienced stereotyping, prejudices and disadvantages as a midwife both pre- and post-regulation. This often took the form of hostility from obstetricians and fellow nurses as well.

### 2. Pre-Regulation

26. I faced many challenges prior to regulation, much of which is described in Vicki Van Wagner's 1991 thesis, "With Women: Community Midwifery in Ontario".[2]

27. For example, during this time, I experienced being treated with disrespect when I accompanied a midwifery client to a hospital. In my early practice, I transferred a client into a hospital for a retained placenta. I was barred from the hospital and the client was made to feel by hospital staff that she deserved the outcome (a manual removal of the placenta without anaesthetic) because she had chosen a midwife.

### 3. Post-Regulation

28. Stereotypes and prejudices continued post-regulation. In particular, I frequently experienced physicians criticizing my practice in front of my client, which I observed was not a practice between physicians. It was apparent I was not part of their world and considered a lower status professional who was not accorded the respect and courtesy of a colleague.

29. As a nurse during the period 1994-1997 at Guelph General Hospital, I frequently heard both physicians and nurses criticize the care of midwives with whom they had contact. For example, "she is an idiot" - "she is incompetent". I felt like I often had to defend midwifery when I was at work.

## III. THE UNIQUE CHALLENGES OF RURAL AND REMOTE PRACTICES

### 1. Overview

30. Since regulation in 1994, more and more rural and remote practices have opened up. However, it rremains an extremely difficult way to practice.

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2 Vicki Van Wagner, With Women: Community Midwifery in Ontario, M.A. Thesis (1991) AOM0017358.

31. “Rural” practices are ones which are in non-urban areas that are accessible by transportation and have access to level 2 hospitals but with significant transport time. “Remote” practices are generally in northern Ontario and access to transportation and hospital facilities beyond a level 1 hospital are very limited.

32. Midwives in some small cities provide a mix of urban and rural services. Other practice groups who have a substantially rural or remote practice face difficulties in growth.

33. Originally, rural and remote practices were not attractive to new graduates and this recruitment problem had an impact on the sustainable growth of these practices. Sometimes new registrants did not stay beyond their first year of practice. Restrictions on the new registrants (who could not work with a second attendant) increased the workload of the senior midwife.

34. Because of the dispersed population in rural and remote areas, it is hard to build enough caseload to have several midwives working in the practice group to allow adequate time for the practising midwives to be “off call”. The majority of remote practices are sole midwives who get very little time “off call”.

**2. No Obstetrician Backup**

35. The 2012 Joint Position Paper on Rural Maternity Care, prepared by the Joint Working Group of the Society of Rural Physicians of Canada, the Maternity Care Committee of the College of Family Physicians of Canada and the Society of Obstetricians and Gynecologists of Canada, called for a regionalized risk management system for low-risk maternity care populations, where local maternity care units are maintained alongside an efficient system for transfer to specialist (surgical) services when needed.[3]

36. In some areas where midwives work, there is no obstetrician backup as very few level 1 hospitals have obstetricians. Rather, the midwife works on her own or with a family doctor to do births. If there is a complication, the client is transported out to a level 2 or level 3.

37. For example, clients on Manitoulin Island are transported to a level 3 hospital in Sudbury. These midwives are more likely to deal with emergency situations for longer periods of time because of their isolated locations, which results in more responsibility and more stress.

3 "Rural Maternity Care" SOGC Joint Position Paper (Replaces #72, April 1998) (October 2012) AOM0017391.

### 3. Increased Travel Time and Home Visits in Adverse Conditions

38. Rural and remote midwifery entails a tremendous amount of driving to reach clients for home births, home visits and to travel to hospitals—often in harsh weather conditions, and often on isolated roads. As a result, most rural and remote practices must use 4WD vehicles. Many must put studded tires on their cars in the wintertime.

39. As well, when the above-noted midwife on Manitoulin Island is on vacation, this means that there is limited option for any local birth. So more women are travelling to Sudbury for their care – a two hour drive when they are in labour.

40. Some practices have patches of their catchment area that do not have cell phone coverage. This means that if there is an accident in one of these areas they cannot call for help. Other practices have found that they have to invest in a satellite phone to practice midwifery safely. This is approximately a $3000.00 upfront investment, in addition to a monthly service fee. It took one midwife two years for her OMP grant application to be approved so that she could purchase this satellite phone which is a necessary practice tool.

41. Several practices have client populations, like Old Order Mennonites and Amish, for example, that usually require home births and home visits for cultural/religious reasons. This means that instead of travelling for the usual five home visits over a course of care they must travel to the client's home for seventeen home visits in addition to the birth. My practice group has about 50% Old Order clients. Yet we are only compensated for the mileage and the time in travel for 5 of these home visits. Extra time is allocated under the time in travel variable which does not cover all of the extra time and travel and wear and tear on our vehicles.

### 4. More Extensive Hospital Relations

42. Many rural practices have privileges at several hospitals in their catchment area because the catchment area is so large. This means that midwives can have two or three times as many hospital relationships to manage as some other practices. It can be added work to maintain and coordinate all these relationships. For example, as a midwife with privileges at North Wellington Hospital (three hospital consortium) Listowel Hospital and the Stratford General Hospital, I am required to participate in professional practice committees at all three hospitals. This also results in extra driving to these hospitals.

### 5. The Costs of Smaller Practices

43. Almost all rural and remote practices are small or solo practices. This means that midwives can be on call twenty four hours a day, seven days a week, for most of the year. Some examples of this extensive on call requirement are as follows:

(a) When the Muskoka midwives started their practice, they had no vacation for two years, maintaining 24/7 coverage throughout this period.

(b) In the Manitoulin Island practice, the midwife just books off a month, and otherwise is on call 24/7 for 11 months of the year. This was also true until recently for the Powassan practice.

(c) The midwife in Kenora, who was a solo midwife with a new registrant (NR) for two years, had to be on call 24/7 to cover the NR. It was several years before she was able to recruit a new registrant who stayed beyond the first year and then allowed her time off.

(d) The midwife in Huron was solo for many years, booked time off for vacation and otherwise was on call. She referred to midwives in the surrounding areas the clients she was not able to accommodate.

44. Often, rural and remote midwives will have a smaller caseload due to lower demand. This also means less operating income, since operating income is tied to the course of care. Rural and remote midwives do not have economies of scale in running their office and they have fewer operating funds. Where possible, some midwives will pool their operating income in order to run their practices and rent a space.

45. As a result, many rural practices operate very close to the line financially because of the impact of the operating funding practices on such small practices.

46. As well, our compensation model does not adequately reflect the responsibility in rural and remote practices of this extensive on call time.

### 6. Difficulty Attracting and Retaining Rural Midwives

47. The ongoing lack of effort to help rural and remote practices get established, to attract practice members, and retain midwives has resulted in a small number who practice rurally, and an even smaller number who stay.

48. Rural and remote midwives tend to have a more difficult time recruiting new registrants. New graduates are expected to work with experienced midwives, and cannot attend births without another midwife. This is much more feasible, as per regulations set out by the College of Midwives, in a practice with many midwives, where the student can shadow a number of different midwives at work, but most rural midwifery practitioners have solo or extremely small practices. It can also be difficult for small, under resourced communities to obtain hospital privileges for new registrants.[4]

4 Report by AOM re: Results of MOH Hospital Integration Survey (2005) AOM0005926.

49. Further, unlike physicians, midwives have never been able to get a tuition supplement as an incentive to practice in rural and remote areas, despite repeated requests to the OMP.

50. As a result, until about 2012, Huron Community Midwives was unable to retain a second midwife for more than a year**.** Huron has finally grown to three midwives. The midwifery practice in Powassan had similar issues also because the North Bay Hospital would not extend hospital privileges to more than a total of three midwives. (There is another midwifery practice group in North Bay.)

### 7. Second Midwives and Second Attendants

51. The College of Midwives requires that there is a second midwife or second attendant at each birth. A **second attendant** is a skilled person whose role is to provide assistance to the **midwife** during birth and immediately thereafter .

52. There are earlier call-in times for second midwives, because of travel times and weather. For those in urban practices, a second midwife may not be called until quite late in the labour and can reach the delivery quickly. In rural and remote practices, second attendants and midwives are generally called in much earlier because of travel and weather considerations, thus considerably extending the time worked. Yet such second attendants are not paid well enough to take on the role as a full time job.

53. There is a highly inadequate second attendant system for practices of one to three midwives who rely on second attendants regularly to run their practices. Relying on second attendants who are not midwives or nurses may be riskier. They are not trained as midwives and do not have the same skills sets. This puts more responsibility on the individual midwife.

### 8. Higher costs of Travel and Commodities

54. Rural and remote midwives have high costs of travel, including for continuing education, and often face higher commodity and accommodation prices and additional expenses, e.g., satellite phones and studded winter tires.

### 9. Additional Needs of some Communities

55. Some communities have higher rates of characteristics that require additional time by the midwife. For example, in some of the communities I served, there are high rates of genetic issues. As a midwife I then work with a geneticist, which can require considerable additional time. As an example in the community I service, many of the people from rural Amish and Mennonite communities do not find regular prenatal classes acceptable, so as midwives, we will do additional education for these groups.

### 10. Isolation and Impact on Family

56. Besides the professional isolation, there is also the social isolation—fewer opportunities for self, family, spouse in terms of employment, schooling, cultural opportunities.

57. Rural and remote practices impact adversely on family income and life. For example, the partners of midwives have fewer opportunities for employment income in these areas. Children often have lesser educational opportunities. For instance, I had to locate in my current area in order to get access to a more robust curriculum for my child at Elmira High School. This curriculum was not available in Listowel or Palmerston.

58. Because of extensive travel required and earlier call-in times, rural and remote midwives can be away from their families for longer periods of time. This can create greater child care challenges.

## IV. PRE-REGULATION

### 1. The Aspirations of Rural and Remote Midwives in the Process of Regulation

59. Midwives have been practicing in rural and remote parts of Ontario since long before regulation.

60. Rural midwives had high aspirations for how the process of regulation would impact our practice. In particular, we had hoped that midwives would be able to help fill gaps in maternity care in rural and remote communities in order to ensure that women had access to good care during their childbearing years.

61. In steps leading up to the regulation of midwifery in 1994, a study was conducted by the AOM Funding Committee to determine, among other things, what would be a reasonable caseload for midwives and what their working conditions should be. Even at an early stage of midwifery, there was already an acknowledgment that midwives working in rural practice may require a reduced caseload to accommodate the increased distances and travel time for births and home visits [5] and that any funding arrangement should be flexible to account for a diversity of characteristics like geography, cost of practice, and travel time.[6]

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5 Report by AOM Funding Committee re: Caseload and Working Conditions (2003) AOM0002003 at p. 5.

6 AOM Principles of Funding and attached AOM document' How Much Should Midwives Be Paid? The Issue of Equity, July 13, 1993 (July 13, 1993) AOM0001281 at p. 2.

## V. 1994: REGULATION

### 1. Early Difficulties in Establishing and Maintaining Rural Midwifery Practices

62. Midwives working in rural and remote communities were disappointed with the lack of consideration given to our practices in the implementation of regulated midwifery. In the early days of regulation, there was no difference in pay or allowance made for the differences in practice in rural and remote areas, other than the travel allowance. Such provisions were not enacted until the 2008 contract, fourteen years after regulation.

63. At the time midwifery was regulated, the Ministry relied on a 1993 report by Robert Morton and Associates, "the Morton report" to set the compensation for midwives.[7] This report reflected the consensus of the joint AOM/Ministry Midwifery Funding Work Group. The Ministry set the compensation for midwives at the start of regulation on January 1, 1994 at approximately 63% of the maximum rate of the male-dominated CHC family physician or 82% of the start rate.[8] At that time, the CHC physician had two grids: one grid for urban areas and one for rural areas, with the rural areas grid substantially higher. Morton and the Ministry used the lower urban grid for comparison purposes despite the fact that midwives work in the same under-serviced areas.

64. At the time I started practising as a registered midwife in 1997, I practiced near the Woolwich Community Health Centre which was considered an “underserviced area” and therefore CHC physicians were paid on the “underserviced” higher wage grid. There was no higher wage grid for our practice even though we cared for women in an underserviced area.

7 Robert Morton and Associates, "Compensation for Midwives in Ontario: Summary Report prepared for the Midwifery Funding Work Group”, July 26, 1993 [Morton Report] and Midwifery Funding Work Group, “Ontario Midwifery Program Framework”, September, 1993 [Midwifery Program Framework] AOM0000564 and AOM0000579.

8 Robert Morton and Associates, "Compensation for Midwives in Ontario: Summary Report prepared for the Midwifery Funding Work Group”, July 26, 1993 [Morton Report] and Midwifery Funding Work Group, “Ontario Midwifery Program Framework”, September, 1993 [Midwifery Program Framework] AOM0000564 and AOM0000579.

## VI. 1997-2000: LEADING TO DEVOLUTION

### 1. Introduction

65. In advance of devolution, the midwife negotiators were concerned that the new independent contractor status meet the needs of rurally practicing midwives.[9]

66. The difficulty of attracting midwives to the North was revealing itself as a serious problem. In a study conducted by researchers at the Centre for Rural and Northern Health Research Laurentian University on the MEP program, zero midwives from the graduating class of 1997 were planning to practice in the North, and one year later, only one had changed her mind.[10]

### 2. Operational Block Payments

67. In October of 1998, Bonnie Heath, the Coordinator of the OMP notified the AOM that the CHB and the Interim Trustee, LHCHC, were working toward the development of an “operational block payment” as part of an initiative to annualize group budgets. The CHB declined the offer of the AOM to contribute to the process in any way possible, in order to ensure the voices of midwives were represented. The operation block payment included rent, support staff salaries and benefits, and all previous LMCO operational funds.

68. The LMCO/LHCHC process for determining the new operational block payments based on their projections of the practice groups’ budgets—rather than the actual budgets of FTEs. It was implemented as a budget on December 1, 1998. This shift in budget had a particularly adverse effect on rural and midwives, because the block payments did not account for our unique practice conditions, like rental situations and travel allotment.[11]

69. Rural Midwifery Practice Groups started to vocalize serious concerns about the way the funding allocation was seriously harming rural midwifery practices. [12] In October 22, 1998, the Barrie Community Health Centre TPA Midwifery Practice Groups drafted a framework regarding "Input Towards Funding Agreement Principles," which demanded that "the differences in resource allocation and the

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9 AOM Devolution Strategy Team 's Negotiations Discussion Document from J. Harrison to AOM members B. Lynch, W. Katherine, B. Soderstrom and E. Johnson and others (1997-07-05 est) AOM0003750.

10 Summary of the 1997 Cohort of Graduates of the MEP, submitted to the MEP by Raymond W. Pong, PhD and Dianne Stewart, BScN, RN, Researchers at the Centre for Rural and Northern Health Research Laurentian University (January 3, 1998) AOM0005300.

11 Letter from AOM Bridget Lynch to LHCHC OMP Trustee Cathy Paul re FTE calculation - block fees (January 21, 1999) AOM0001987.

12 Letter from Niagara MPG to Lawrence Heights CHC re budget shortfall (February 8, 1999) AOM0012857.

need in the varied demographic areas across the province, be recognized and accommodated in the funding agreement."[13]

## VII. 2000 DEVOLUTION CONTRACT

### 1. Introduction

70. The devolution contract in 2000 had a number of adverse impacts for rural and remote practices, which included the following:

### 2. Mileage

71. With the 2000 devolved contract, practice groups were given a flat rate payment for mileage per course of care based on their previous mileage usage.

72. A travel grant was provided that ranged from $80 per course of care in the urban core to $200 per course of care in a rural-dispersed population (Schedule "D" Disbursements). This grant is to provide midwives with a reimbursement for work related travel expenses. Owning a car in order to travel to client's homes, clinics and hospitals is a job requirement for midwives. This is a work related expense that CHC physicians do not have and, therefore, would not receive a travel grant.

73. This amount has not changed since. As a result, in 2016, I am still getting the same mileage reimbursement I started getting in 2000 even though car costs and travel have risen substantially.

74. Prior to 2000, we were paid on a sliding scale for mileage. After 2000, the OMP calculated the mileage allowance per course of care. Now we received $200 per course of care to pay for gas, wear and tear. $8000 per year for 40 courses of care does not cover the costs. This had a disproportionately adverse impact on small and solo remote practices who did not have the population size to sustain full courses of care, but who had higher travel and operational expenses.

75. Remote practices like Temiskaming Shore and Kenora only get $200 as well, but this is extremely insufficient for a remote practice in northern Ontario.

76. Any new practice has to put forward an argument to get the appropriate higher mileage rate.

### 3. Caseload Variables

77. Post-devolution, caseload variables were created to acknowledge the work midwives do that was not originally foreseen in the breakdown of midwives'

13 Draft Framework re Input Towards Funding Agreement Principles by Barrie Community Health Centre TPA Midwifery Practice Groups including comments on rural and remote midwifery issues (October 22,1998) AOM0002320.

responsibilities, or the variations in practice that create more work for midwives. There were six caseload variables available: Client population, non-clinical activities, distance/catchment area, supervision, new registrant and practice development/new midwife.[14] Examples of issues with respect to some of these variables are set out below.

(a) **Time in Travel**

78. By 1998, rural midwives could claim a variable for time spent travelling ("time in travel"), but we could only claim 5% of our total courses of care of the practice group, or two additional courses of care for travel per FTE midwife. This was never commensurate with the actual additional time and expenses that travel demanded.

79. In order to get this 5%, we had to document every visit and time in travel, which was a considerable administrative burden. A typical course of care is 48 hours. Therefore, a midwife could access the full travel variable if she spent 96 hours per year in additional travel time. However, most rural midwives spent far more time that that in transportation. For example, midwives in my practice, Countryside, routinely have more than 40,000 kilometres in travel in a year. This works out, conservatively, to 500 hours of driving at 80 km/hr, not 96.

80. In general, rural and remote practices used all of the applicable caseload variables to the maximum allotted by the OMP. However, they often found it very onerous to make their claims. At one point, we had to account for each home visit in minutes of travel time.[15]

(b) **Special Client Populations**

81. This Special Client Populations Variable is limited to three courses of care per practice. If a practice provides midwifery care to vulnerable groups who are considered special client populations, they will often have to provide the care without sufficient compensation as the extra time spent caring for these women is far greater than the three courses of care allotted by the Ministry. For example, when I provide care for non-English speaking clients through a translator it usually doubles the amount of time that I spend with a client. This is not covered by the three courses of care.

14 Caseload Variable Usage Report 1996-1998 (November 23, 1998) AOM0010564.

15 For example, see letter from Countryside Midwifery Services and Stratford Midwives to C. Paul (Trustee, Lawrence Heights Community Health Centre) re: Caseload Variable Report (December 22, 1999) AOM0012929.

## VIII. 2003-2004: AOM REVIEW OF ISSUES FACING RURAL AND REMOTE PRACTICES

### 1. 2004 AOM Issues Paper

82. The AOM undertook an extensive process over 2003 to 2004 to identify the challenges facing solo and small practices in Ontario, most of which operate in remote, underserviced areas. The results of this process were reflected in the July, 2004, AOM Issue Paper - Small Practices which I contributed to developing.[16]

83. This paper concluded that changes were needed to the funding agreement to ensure the sustainability of small practices. The sustainability of midwifery practices is key to ensuring the women are able to give birth in their own community. Because of the lack of alternative obstetrical providers in these communities, the alternative is forcing women to give birth far from home in hospitals, or having women choose to have a home birth unattended by a health care provider. The following recommendations came from that process:

(a) Core Funding

84. Small midwifery practices should receive a minimum amount each year to fully fund the core costs of running a midwifery practice (operating and administrative), while acknowledging their role as independent contractors. To accomplish this, each practice should be given an amount equal to their core costs as the fixed component. In order to qualify, a midwife would have to provide some minimum level of births per year, and should be available to practices with up to approximately 80 births per year.[17]

85. For 2003, the amount required for core funding was estimated at $38,300 annually. The required core funding should be reviewed before implementation, and subject to periodic review to address inflation. There may be a need for criteria to determine eligibility to receive this amount.

(b) Second Attendants

86. Second attendants require an increase in compensation after ten years without an increase. The on-call allowance should also be increased to reasonably reflect the importance and demands of being on call. As well, the hours midwives are compensated for each birth should be increased to more accurately reflect the hours worked.

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16 AOM Issue Paper - Small Practices, re: small practices and challenges with funding agreement (July 26, 2004) AOM0002464.

17 AOM Issue Paper - Small Practices, re: small practices and challenges with funding agreement (July 26, 2004) AOM0002464 at p. 3.

87. Second attendants should receive a minimum of $250 per birth, plus an on-call fee of $25/day. The annual cost of a pager or cell phone ($800) and travel expenses of up to $2,400 should be available.

88. To increase the training of second attendants, funding should be available for professional development, including a voluntary emergency skills workshop (ESW) attendance.

(c) Model of Care

89. As outlined in the Consensus Statement on the Model of Care, the AOM, CMO and OMP should continue their efforts to find opportunities to allow more collaboration between solo midwives and general practitioners providing obstetrical care and nurse practitioners. For midwifery clients, this could allow midwives to form a team with other health practitioners to support the midwifery model of care while allowing more flexibility, including time off call. Any changes should allow for fair compensation for all health care providers.

## IX. 2004-2005 FUNDING NEGOTIATIONS AND CONTRACT

### 1. AOM Principles and Goals for New Funding Agreement

90. Flowing from the above Issues Paper and the concerns of midwives like myself, in the AOM Principles and Goals for New Funding Agreement in 2004, referred to a priority of "addressing pressures of solo and remote practices (core funding, practice insurance, travel)".[18]

### 2. Negotiations

91. In the end, the issues affecting rural and remote midwives were not appropriately addressed in the 2005 contract. Given the limited budget which the Ministry was prepared to provide for that contract, the AOM's first priority was to address the Ministry's lack of attention to the base compensation of all midwives.

### 3. Concerns about the 2005 Funding Agreement

92. Nevertheless, rural and remote midwives had some serious concerns about lack of attention to rural and remote practices in the funding negotiations and contract. This is reflected in the letter from Midwives Grey Simcoe, Barrie Midwives, and Midwives*Sages-Femmes of North Bay to AOM President Elana Johnson.[19] We ended up having to wait for the next round of negotiations to address these concerns.

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18 AOM Principles and Goals for New Funding Agreement (June 30, 2004) AOM0002445.

19 Letter from Midwives Grey Simcoe, Barrie Midwives, and Midwives*Sages-Femmes of North Bay to E. Johnson re: Compensation Offer (March 25, 2005) AOM0002527.

## X. 2007: CREATION OF RURAL/REMOTE WORKING GROUP

93. I joined the AOM Board as the Western Regional Representative in 2007 to focus on getting these issues were addressed. At that time, I promptly started the Rural and Remote Working Group which assisted AOM staff and Board with identification and understanding of our issues. Initially, there were two separate working groups—one for Rural Midwives and one for Remote Midwives, but we soon realized that the issues were similar enough that we merged the groups to save time and energy of AOM staff.

## XI. 2007: WORKLOAD ANALYSIS STUDY

94. I was involved in the Workload Analysis Study. As a part of the Workload Analysis Study, members completed a survey about practice profiles, which then fed into the workload analysis survey, in which members described their practice as Urban, urban-rural, rural, or remote.[20]

95. One objective of the 2007 midwifery workload study was to examine how clinical and non-clinical activities might vary according to the level of rurality. At that time, there was no definition of rurality in the AOM-Ministry Funding Agreement. There were categories of rurality for "travel disbursements," or amount of money that practices are given to cover their mileage costs for servicing clients in their area, but their allocation was at the discretion of the government.[21]

96. We found that practices with a very high home birth rates occurred in rural, remote, and urban areas, and that the highest home birth rate (at 85%) was in a remote area**.**

## XII. 2008: NEGOTIATIONS

### 1. Introduction

97. From these working group discussions, the staff and I created proposals for the Negotiations Committee. I was also on the Negotiations Committee at that time.

98. I was called into the negotiations meetings in 2008 to make a presentation to the AOM-MOHLTC negotiations meeting about the funding and compensation needs of rural and remote midwives. My presentation highlighted the concerns I have described earlier in this affidavit.

99. We were able to achieve some progress in these negotiations.

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20 AOM Survey re: Practice Profile (2007) AOM0005605.

21 Report by AOM re: Finding of Midwifery Workload Study (August 1, 2008) AOM0005588.

100. The Ministry's Wendy Katherine asked the AOM to forward its "list of priorities," which we did by letter dated April 30, 2008 from the AOM's Elana Johnson to Katherine with the subject heading: "Creating Equity for Midwives in Ontario's Health Care System."[22] It identified substantial compensation increases as a key priority along with a parallel process for regular negotiations and a dispute resolution process similar to those available to physicians and nurses. It also identified the need for midwives to get equitable treatment with other health care professionals with respect to such as issues as professional development, maternity and parental leave, and rural and remote practice provisions. The rural specific proposals were for the rural and remote locum program and the rural and remote supplement.

101. In recognition of the unique challenges in attracting and retaining health professionals to rural, Northern and remote communities in Ontario, the Ministry funded several programs to incent physicians and nurses to practice outside of urban centres. In the 2008 funding negotiations, the AOM requested some commensurate programs for midwives as described below in this Part.

102. While rural midwifery stagnated and struggled, the MOHLTC was making contracts with physicians, provide financial incentives to practice in rural and remote areas, in order to attract doctors to those areas and retain them.

103. Initially, midwives practicing in rural and remote areas did not have access to any incentives, nor did they have any extra funding to offsets additional costs of a rural and remote practice.

104. Even in the time when midwives were dependent contractors, there was no access to MOHLTC programs or grants for expenses associated with living and working in these areas.

105. In order to address the inter professional and intra professional inequities facing rural and remote midwives, the AOM sought additional funding for rural and remote practices similar to the Rural Medicine Investment Program. Specifically, the AOM asked the Ministry to replace the Remote practice grant with the establishment of a Rural and Remote Allowance program. This allowance would be provided to each rural and remote midwife who qualifies, to address costs such as: extra costs due to harsher road conditions; stress; satellite phone; higher commodity prices; and other weather-related expenses such as a backup generator; high costs of travel for continuing education; social and professional isolation, including lack of adequate call-sharing; earlier call-in times in rural areas for secondary midwives; a lack of easily accessible supporting health care resources; and, in remote areas, lower caseload availability and hence poorly remunerated on-call and operating costs.

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22 Letter dated April 30, 2008 from Elana Johnson, President of the Association of Ontario Midwives to Wendy Katherine, Coordinator of Ontario Midwifery Program (April 30, 2008) AOM0000685.

106. This type of compensation parallels the physician Rural Medical Investment Program, which provided remuneration to physicians who provide full time, dedicated patient care in rural communities. The $4.0M program was developed in partnership with the Ontario Medical Association.[23] As well, there is precedent for differential pay for those practitioners working in underserviced areas: Ontario CHC physicians working in underserviced areas earn on average 26.8% more than their CHC physician colleagues elsewhere in the province.[24]

107. We were asking for equity with other health professionals who were provided with financial incentives to practice in rural and remote areas.[25] Examples of the incentives provided by the MOHLTC to other professional include the following:

    (a) Up to $15,000, paid over four years, to family physicians who relocate to eligible designated southern communities;

    (b) Up to $15,000, paid over three years, to audiologists, chiropodists, occupational therapists, physiotherapists and speech-language pathologists who relocate to fill positions in full-time MOHLTC-funded vacancies in Northern Ontario;

    (c) Up to $40,000, paid over four years, to family physicians and psychiatrists who relocate to designated northern communities;

    (d) Up to $20,000, paid over four years, to specialists who relocate to designated northern communities;

    (e) $20,000 again paid over four years, under the Northern Medical Specialist Incentive Program, to northern specialists who provide a minimum of 12 days of outreach services per year.

108. The AOM argued during this negotiation that midwives are specialists in normal, low-risk birth and should be paid on a more equitably relative to physicians who relocate to a designated community. We also argued that providing incentives to join or open rural or remote practices will allow women across Ontario to have equity in their access to midwifery care.

    The AOM was able to successfully negotiate a small locum program; rural and remote supplements to compensation fees and operational fees, but the Ministry refused to provide any additional incentives to attract midwives to rural and

23 2004 Physician Services Agreement, Appendix K, AOM0000635.

24 2004 Physician Services Agreement, Appendix K, AOM0000635.

25 See our request for incentives Ministry Funding for Growth and Sustainability of Rural and Remote Midwifery Practices (2008-10-28) MOH004306.

remote communities. However, there were significant delays in getting the funding, which created financial hardship for many already strained practices.

**2. Practice Group Mileage Rate**

109. In the 2008 Funding negotiations, we focused on trying to make the rules transparent so that all rural and remote practices were on the same footing with respect to mileage. This issue had been raised with the OMP for many years.

110. In a 2005 letter to Wendy Katherine of the OMP about this issue, the AOM reiterated the need for transparent criteria.[26] In this letter, the AOM was concerned that St. Jacobs Midwives had been reclassified at a rate much lower than neighbouring practice groups that did not care for as many rural women. Because the process of applying for travel grants was very onerous and instructions were unclear, many midwives had the impression that the decision-making process was arbitrary.

111. The only guidance Schedule D of the 2005 funding Agreement provides is "the approved Practice Group Travel Rate is based on the size and geography of the Practice Group Services Area and the distribution of Women, Practice Groups, other health services and the cost of parking within the Practice Group Service Area."[27]

112. Some midwives working in very remote areas would be denied the rate, while others in less remote areas would get it. It was also notoriously difficult for solo midwives to get it. The OMP calculations for mileage in rural and remote areas was not based on the OMA Rurality Index of Ontario (RIO), although it was being used for physicians at the time in the OMA agreement.

113. Rurality Rates are a system created by the OMA and applied in the OMA-MOHLTC agreement since 1999 to apply financial incentives to physicians working in rural and remote areas of the province. The index uses such things as severity of weather, need for snow tires, distance from education options for the families of practitioners, distance from continuing educational opportunities for practitioners, distance from cultural activities, distance from consultants, etc in rating the rurality of a practice and its clients.

114. The Rurality Rates in the Rurality Index of Ontario system operates as follows: The rurality of the practice is determined by the rurality of the geographic location of the practice base, as well as the rurality of the clients. In my practice, 70-95% of the practice is considered rural. However, Listowel is a town in our catchment area, and is therefore not considered rural.

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26 Email from M. Heitshu to D. MacNab, forwarding email from M. Heitshu to W. Katherine, copying AOM staff, re: remote grant (September 8, 2005) AOM0001834.

27 Funding Agreement 2005, schedule D MOH008855.

115. We requested that there be overall a:

> *…transparent, agreed upon way of defining eligibility for rural/remote incentives and/or grants, such as the Rurality Index of Ontario (RIO) (using not the clinic postal code but the average postal code for each catchment area), or some modified version of it, and if the RIO is used, that the AOM be an equal partner in negotiating what the appropriate cut-off will be foe each program.*[28]

116. I worked with AOM staff to come up with the RIO score threshold that would best reflect the reality of rural and remote midwifery practice. We were given the OMA's RIO guidelines and we came up with a process of applying that guideline to the MPGs.

117. While we were not able to achieve any increase in the mileage rate, we were able to get transparency on how the rate was calculated for each practice group.

### 3. Rural/Remote Incentive Fee

118. In the 2008 Agreement, the AOM was finally able to get the MOHLTC to provide a Rural/Remote Incentive to offset the additional costs and time of providing rural and remote midwifery care.[29] To incent midwives to stay in the rural and remote environment, the fee was graduated to increase with years of experience.

119. This incentive was based on the RIO which provided some consistency and transparency. However the details were not finalized regarding this program at the time the AOM accepted the offer. For example, we later had to argue for the inclusion of midwifery practices who worked on reserves which were not being covered under the Index.

120. It had taken a very time for rural and remote midwives to start to get the specialized consideration which had been available through a multitude of programs and incentives available to physicians, including relocation grants for physicians, tuition reimbursement for both doctors and nurses who serviced designated communities. These program and incentives had used the RIO calculations.

### 4. Locum Program

121. The AOM requested that the Ministry address the inter professional and intra professional inequities facing rural and remote midwives, and sought a funded locum program similar to the Urgent Locum Tenens Program for Specialist

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28 AOM Negotiations Committee Meeting Draft Agenda and Funding Agreement Proposals (June 18, 2008) AOM0002663.

29 Description of Compensation Offer to Members from AOM (2005) AOM0001385.

Physicians. Specifically, the AOM requested the establishment of a Ministry funded locum program for rural and remote practices. This program would allow rural and remote midwives to facilitate holidays, continuing education, sick leaves, and attend to family matters. The locum fund would cover, at minimum, accommodation, living expenses, travel time, and mileage costs (including travel to and from the community where the locum takes place). As well, a mechanism for timely processing of the required liability insurance premium for the locum midwife would need to be ensured. Government funded locum programs for physicians were widespread across the country including an active program in Ontario. In Ontario, a physician could choose to bill fee-for-service to OHIP, or claim a daily stipend of $590, plus expenses including travel and accommodation. Ultimately, the Ministry did agree to establish a small $100,000 locum program administered by the AOM.

**5. Tuition Reimbursement in Exchange for a Return-of-service**

122. The AOM also sought a tuition reimbursement program for rural and remote midwives in exchange for a return-of-service to designated communities, similar to the Free Tuition Program for Physicians and the Grow Your Own Nurse Practitioner Program. This was denied by the OMP.

123. As birthing units continue to close in rural and remote areas, the AOM argued that it was becoming increasingly imperative that midwives be available in these communities to ensure that birth can be maintained as close to home as possible. Providing care options to women living in these areas is an ethical issue and a quality of care issue, and the current funding agreement did not provide incentives for midwives to practice in such communities. Midwives also require these incentives to attract new practitioners to rural and remote areas, allowing midwifery clients to be served in their local communities.

124. MOHLTC offered parallel programs at that time for doctors and nurses.

(a) For example, the Free Tuition Program for physicians offered up to $40,000 (or $10,000 per year) in exchange for a three or four year return-of-service commitment. Midwifery tuition fees are one third of that of physician's; therefore this program would have cost less per midwife than that paid by the government per physician. The program provided reimbursement of medical undergraduate tuition fees and a location incentive fund. The program compensated medical students and postgraduate trainees for actual medical tuition payments (to a maximum of $10,000 annually), in exchange for a return-of-service commitment in a community designated as underserviced or an undersupplied specialty. The location incentive fund may provide tuition grant candidates with additional financial incentives to locate to approved communities if tuition is less than $10,000 per year.

(b) The Tuition Support Program for Nurses offers tuition reimbursement to recent nursing graduates from rural and remote communities in exchange for a return-of-service in an eligible underserviced community.[30]

### 6. Further 2008-2009 Negotiations Re: Requests

125. The Ministry initially refused the above requests. Despite the compelling nature of our requests for rural and remote midwives, we encountered significant resistance form the OMP to making changes which would increase their funding budget. This was very upsetting as we were still being undervalued and having to fight very hard to get our work and operating costs funded properly.

126. However, on August 28, 2008, Rena Porteous, of the OMP, prepared a proposal that acknowledged that rural midwives face the same challenges in maintaining services and in recruiting and retention as other health professionals working rurally, compounded by the administrative burdens of operating their own practices. The rationale provided to support their proposed was "In order to address the inter professional and intra professional inequities facing rural and remote midwives". It also itemizes the kinds of programs available to physicians to support rural practice.[31]

127. In the fall of 2008, Health Professionals Regulatory Advisory Council (HPRAC) published their “Interim Report to Minister of Health by HPRAC re: Mechanisms to Support Inter professional Collaboration among Health Colleges and Regulated Health Professionals.”[32] This was very significant because it recommended the increase of the scope of care for midwives. Such an increase would have an especially positive impact on rural and remote midwives, who are often under-supported by physicians. We used this document to support our submissions to the OMP and Minister of Health, regarding these negotiations.[33]

128. In October of 2008, the AOM produced a further funding agreement proposal.[34] It included the following proposals regarding rural and remote practice:

(a) A clear definition of "rural" and "remote" midwifery

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30 AOM Funding Agreement Proposal (2013/11/27) AOM0008712.

31 OMP Proposal for AOM-MOHLTC Negotiations drafted by R. Porteous Re Rural and Remote Practices (August 28, 2008) AOM0012366.

32 Interim Report to Minister of Health by HPRAC re: Mechanisms to Support Interprofessional Collaboration among Health Colleges and Regulated Health Professionals” (2008-09-01 est) AOM0005928.

33 Letter from K. Kilroy and K. Stadelbauer to D. Caplan re: AOM Response to HPRAC Recommendations regarding Midwifery Scope of Practice (January 30, 2009) AOM0005921.

34 Funding Agreement Proposals from AOM to MOH (October 1, 2008) AOM0000686.

(b) Rural and Remote Practice Allowance Program

(c) Rural and Remote Practice Second Attendant

(d) Rural and Remote Practice Locum Program

(e) Rural and Remote Practice Incentive Grant or Open a Rural or Remote Practice

(f) Rural and Remote Practice Tuition Program

129. The MOHLTC made a presentation to the AOM dated February 23, 2009 and proposed 2% for base fees, 2% for operational expenses for 2008 and 1% in 2009-11 with increase in benefits to 20%.[35] The offer did not include any equity pay adjustments.

130. The AOM proposal provided for a new parental leave program, administered by the AOM similar to the physicians' program in order to protect midwives' independent contractor status; a new professional development program modelled after the professional development programs that other health professionals can access providing up to $1500 per midwife per year; a $100,000 Locum program for rural and remote midwives; a rural and remote compensation fees supplement and operational fee supplement for midwives working in such communities; a $100,000 special populations grant to meet needs of specific groups of midwifery clients; and a $100,000 inter professional grant to assist with hospital integration work; and second attendant funding of $18,000 for small rural and remote practices.

## XIII. 2009: AOM-MOH CONTRACT PROVISIONS

### 1. Introduction

131. As a result of the above negotiations, we were able to achieve some improvements for rural and remote midwives, although many inequities remain.

### 2. The Terms

132. The AOM and the MOHLTC entered into a new Memorandum of Understanding signed May 7, 2009.[36] It provided for:

35 Ministry of Health and Long Term Care, "Presentation to the Association of Ontario Midwives", February 23, 2009 (September 2008) AOM0005928.

36 Memorandum of Understanding between Her Majesty the Queen in Right of Ontario as represented by the Ministry of Health and Long Term Care and the Association of Ontario Midwives, (May 7, 2009) AOM0001231.

(a) an increase in the course of care fees of 2% annually as of April 1 of 2008, 2009;

(b) introduced the experience fee for rural/remote supplements and operational fee supplements for small rural or remote practices;

(c) increased the benefits from 18% to 20% of salary; introduced a professional development program similar to those long standing programs provided to physicians ("the CME program") and to other health professionals ("the Allied Health Fund"); and

(d) included a parental leave program..

**3. Midwifery Experience Fee**

133. Under the new contract, the experience fee increased with a midwife's experience and time in rural or remote practice. The fee was not an annual payment but $175 per basic course of care (BCC) x 40 courses of care per year. This works out to $7000 per year. First and second year midwives did not have access to the full $175. A midwife working in a rural and remote area in her first year of practice could make $5,000 per year ($125 x 40BCCs) and a midwife in her second year would make $6,000 per year ($150 x 40 BCCs). The $175 supplement on top of the course of care is the maximum, and tops out after three years of practice.

134. Prior to 2008 negotiations, there was no stipend to be attached to each course of care for midwives practicing in rural and remote areas.

135. This experience fee has not increased since the 2008 agreement and falls short of the incentives used to attract other practitioners to remote and rural practice.

136. Similarly our HRTO application, in calculating the CHC physician salary used the lower non-underserviced areas salary grid which is provided by MOHLTC to CHC physicians even though midwives are often operating in underserviced areas where CHC physicians are getting the higher grid. Unlike the small rural and remote supplement provided to midwives, CHC physicians entitled to the higher "underserviced" grid earn at the top level more than $35,000 than the top level of the non-underserviced salary grid. See Application para. 299. If this midwifery rural and remote supplement is included then it will be necessary to factor in the higher underserviced CHC salary grid. See para. 33 of Application which currently uses the top of the lower CHC Physician non-underserviced grid as the compensation figure for the CHC physician (a figure which does not yet take into account differential value of benefits.)

### 4. AOM Rural and Remote Locum Program

137. In the 2009 MOH-AOM MOU, the Ministry also agreed to fund the AOM Rural and Remote Locum Program.[37] The Program was then developed that summer.[38] The program was designed to provide funding for short-term locum relief for practices that the MOH designated as "rural" and "remote" in the 2009 Funding Agreement. There are detailed criteria to determine whether a practice is appropriately designated as rural.[39]

138. This program was created in response to the needs of rural and remote midwives to have relief for holidays, sickness, emergencies and continuing education, and to incent locum midwives to apply for parental leave replacements in these locations.[40]

139. The reasons for relief requests can include planned and unplanned leaves of absences (sick, family emergency, etc.) The program aimed to decrease the financial burden on the resident midwife (midwife on leave) when a locum midwife provides relief. Prior to 2009, the resident midwife would pay the locum midwife the entire course of care when she is on leave.[41] The program subsidizes the resident midwife and pays the locum midwife even when there is no birth. For locum midwives who do not already have insurance coverage, their insurance is paid for by the Ministry.

140. Once a locum midwife and a resident midwife agree on the duration of the relief, the AOM is notified and if funds are available a contract is signed by the three parties (locum midwife, practice group partner on behalf of the resident midwife, and AOM). The contract details the expense reimbursement limits, benefits transfer to the AOM Benefits Program, and payment structure/amount for relief services.

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37 MOU between Her Majesty the Queen in Right of Ontario as represented by the Ministry of Health and Long Term Care and the Association of Ontario Midwives (May 5, 2009) AOM0001231 at p. 3.

38 Letter of Proposal to Rena Porteous from Kelly Stadelbauer re: Rural and Remote Locum Program (2009-07-27) AOM0001234.

39 Description from AOM for Members re: Rural and Remote Locum Program (December 4, 2009) AOM0001232 at pp. 1-2.

40 Description from AOM for Members re: Rural and Remote Locum Program (December 4, 2009) AOM0001232.

41 Details of the program is included in 2009-10 MOH approved funding proposals and budgets and the AOM program package for midwives. The program structure and funding stayed the same until January 2012. AOM0001232.

141. The following expenses of the locum midwife are covered by the AOM locum fund:[42]

(a) Travel (to and from practice location, with receipts)

(b) Meals ($40/day no receipts required)

(c) Accommodation (up to $90/day with receipts or $30 without receipts if staying at the home of the resident midwife)

(d) Car rental (up to $50/day including insurance with receipts)

142. In the development of this program, the AOM worked with AOM rural and remote work groups to develop a viable locum proposal, as well as with HIROC to develop a mechanism to insure retired/inactive midwives who want to become active for the purposes of doing a locum. Finally, we also worked with the College to establish registration requirements for retired/inactive midwives to become active for the purposes of participating as a locum. We then proposed the program to the OMP.[43] The Program was finalized in the spring of 2010.[44]

143. Ultimately, the Ministry has control over payment structure and amount provided to locum midwives who are enrolled in the program - the Ministry determines the amount of funding available per year, the amount locum midwives are paid and how locum midwives are paid. The program requires annual proposals from the AOM and is subject to approval each year. That is, there is no certainty from year to year that this program will continue unlike the physician program which is administered by the Ministry.

144. These two programs really helped to increase recruitment and retention in rural and remote practices. The Countryside Practice grew from 3-4 midwives to 10 midwives.

## XIV. 2010-2011: NEGOTIATIONS

145. I was at the table for most meetings as a part of the team and the negotiating committee.

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42 Description from AOM for Members re: Rural and Remote Locum Program (December 4, 2009) AOM0001232 at p. 2.

43 Letter of Proposal to Rena Porteous from Kelly Stadelbauer re: Rural and Remote Locum Program (July 27, 2009) AOM0001234.

44 Final Report by AOM for OMP re: Locums Program Grant (April 30, 2010) MOH000340.

### 1. MOHLTC Proposal to Update RIO Calculation

146. At this time, the MOHLTC required that the RIO calculation in our Contract be changed to match the revised RIO calculation agreed to by the MOHLTC in the OMA agreement. As a result, we had to adapt the new RIO calculation to midwifery care without being provided with additional budget adjustments to reflect the impact of the new calculation.

147. n our MOHTLC Negotiations in January of 2011, we proposed updated definitions of “rural” and “remote” which are now contained in the Funding Agreement.

148. The rationale for our proposed calculations in these 2011 negotiations are outlined below:

> *In 2008 the RIO system was changed to a more stable system for determining rurality and remoteness of communities. Since the system used in 2004 (used by midwives up until the end of the current funding agreement) will not be adjusted over time, it is desirable for midwives to use the same system in current use by the OMA and the MOHLTC. The rurality index is just that, a tool to measure the rurality (and remoteness) of a community. The application of the index is to be decided in negotiations and will be part of the next funding agreement.*
>
> *The changes from the 2004 RIO to the current 2008 RIO would affect the allocations of several practices, yet within the Stats Can definition of rurality, those practices would be rural. Thus we propose lowering the cutoffs to reflect this. In addition, the lower cutoff helps to adjust for the differences in midwifery care that we felt were captured in the previous RIO of 2004. Midwives provide care in the home, and therefore distances between the home and the referral centres is of greater importance. Weather patterns are significant (especially snow) when home care is involved, as is ambulance transport. We have therefore suggested a lowering of the RIO allowances. This will allow all practices that are currently designated as rural to continue with this designation. For those that do not meet current OMA definitions (RIO of 40), the use of the statcan rurality definition shows that they are indeed rural. With the lowered cutoff there should not be large changes to the numbers of practices or BCC's qualifying for the rurality supplements, except by growth of practices and new practices that have been approved.*
>
> *Previously, 5 practices were designated as remote, the new system would have 9. All but one practice are solo practices. We have proposed that it is not necessary for a practice to be solo in order to be designated as remote, as the designation should be geographic, and we do not wish to provide a disincentive to growth. In addition, it is possible that two or*

*three midwives would like to work part-time in some remote communities. The designation of remote is important for eligibility for other funding and grants outside of the rural/remote RIO incentive program. There were 13 practices eligible for rural incentives in the 2004 RIO system, with proposed changes and program growth there will be 10 designated as rural, and a further 8 are mixed urban/rural that may be eligible if they have more than a 35% proportion of clients who have RIOs that will qualify the clients as rural. These increases to service for rural and remote women are a direct result of the success of the incentive program. Some practices have responded by opening satellites to better serve the rural women, and new practices have opened in the North as midwives feel more supported in their efforts. In the previous agreement the Rural supplement increased with the experience of the midwife billing the BCC. While this provides an incentive for retention of midwives in rural practice, we also feel that the OMA use of the RIO to provide a sliding scale so that clients and practices with higher RIO's would be eligible for a larger supplement than those with lower RIO's. The proposed differences are quite modest at this time, in order to keep cost increases within what would be expected with program growth. Only the 9 practices designated as remote (10 midwives in total) would be eligible for the larger supplement.* [45]

**2. AOM Rural and Remote Locum Program**

149. This Program was administered by the AOM with a fixed budget set by the OMP.

150. Between 2009 and 2012, the Rural and Remote Locum's program's budget approved annually following the submission of a proposal by the AOM, has have remained the same at $110,000 ($100,000 for midwives and up to $10,000 for admin cost). This was despite the fact that more rural and remote practices were approved during this period. As a result, the fixed funding had to stretch over more practices.

151. The budgets include line items specified for each component of the locum relief (food, travel, accommodation, per diem). For resident and locum midwives enrolled in the program, locum midwives are reimbursed for their expenses (car rental, accommodation, and food). If the locum midwife attends no birth the Ministry, via the AOMs administration, offers the midwife a per diem. If the locum midwife attends one, two, or three births, the program and the resident midwife both pay the locum midwife. The resident relinquishes the course of care payment for every birth the midwife attends. If the locum midwife attends four births, the resident midwife relinquishes 4 courses of care payment and the

45 Email from M. Clin to N. Patton, K. Stadelbauer, L. Weston, K. Kilroy and J. Berinstein re: Soliciting Feedback on Proposed Rural Definition (February 2, 2011) AOM0005976.

program does not pay the midwife. The resident midwife also transfers her benefits to the locum midwife for the duration of the relief.

152. Demand for the program increased throughout the first few years but many rural and remote midwives challenged the funding structure as disadvantaging the resident midwife since resident midwives perceive their relinquishing of course of care as punitive for taking short-term reliefs that are necessary to ensured their health and the practices' sustainability.[46]

153. On January 1, 2012, after notifying the Ministry, the AOM changed the program's funding structure in response to the negative feedback from rural and remote midwives. The program changed to fund the entire portion of payment and benefits for the locum midwife without needing any course of care relinquishment by the resident midwife. The AOM provided an interim report on these changes on January 31, 2012.[47]

154. However, in Fall 2012, the Ministry rejected the changes based on the reason that the changes reflected a "compensation increase" for midwives as no funded service providers can receive a compensation increase due to a wage freeze.

155. The AOM argued that the amount of money locum midwives receive does not change but rather the program now funds the payment's entirety while the resident midwife may provide a portion of the payment in the old program. After rounds of unsuccessful lobbying at MCFAC meetings[48], the AOM reverted back to the original funding structure (as set up in 2009) in the 2013-14 fiscal year. The Ministry has since approved slight increases in expense reimbursement and the benefits changes (the resident midwife does not have to relinquish her benefits and the locum midwives receive benefits from Ministry funding).

156. On June 14, 2013, the AOM submitted a grant proposal for the Rural and Remote Locum Program.[49]

157. The AOM Rural and Remote Locum Program largely remains in its 2009 locum relief funding structure. In the 2013 MOH-AOM MOU, the Ministry increased the program funds from $110,000 to $150,000.[50]

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46 Briefing Note by AOM re: Rural and Remote Locum Program (2013-07-01) AOM0001230.

47 Interim Report by AOM to Cathy Blacklock OMP re: Rural Locum Program (January 31, 2012) AOM0001235.

48 Midwifery Contracts and Funding Advisory Committee Agenda (2012-12-06) AOM0015517; Chart of AOM Proposals at Negotiations Circa 2013 MOH002251.

49 AOM Grant Proposal 2013-2014from AOM Juana Berinstein to OMP Seetha Kumaresh re: Rural Locum Program (June 14, 2013) AOM0001236.

50 Briefing Note by AOM re: Rural and Remote Locum Program (2013-07-01 est) AOM0001230.

158. The Ministry controls how and from what funds midwives are compensated for their locum reliefs. The practice group/resident midwife administers the benefits transfer and any course of care transfer to the locum midwife but does not determine the rate of benefits or payment. Midwives' negative feedback to original program has been repeatedly ignored by the Ministry. Midwives can arrange to provide locum relief services for any practice and do so under the terms agreed upon by the resident and locum midwives. The AOM Rural and Remote Program covers only midwives who enrol in the program and agree to the contract of the program.

159. The Ministry has held control over the funding structure of the program despite protests by midwives over the years. This program is yet another way that midwives have limited autonomy in deciding how they are compensated in services rendered and in the form of benefits, even as they are on short-term contracts provided temporary locum relief.

160. Overall I experienced great frustration and disrespect for the way I and my rural and remote midwifery colleague had to fight for many years to get even small funding adjustments while physicians were provided with extensive specialized funding for caring for the same populations caring for women. It made me feel bitter about our treatment by the MOHLTC as a female-dominated profession, particularly since we were at the forefront of carrying out the MOHLTC's priority of providing care to those populations.

**SWORN** this 27th day of July 2016.

A Commissioner for taking Affidavits

Madeleine Clin