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 ADEREMI (REMI) EJIWUNMI

I, Remi Ejiwunmi, of the City of Mississauga in the Province of Ontario, MAKE OATH AND AFFIRM as follows:

1. I am a registered midwife in the Province of Ontario and have been Head Midwife in the Division of Obstetrics and Gynaecology at Trillium Health Centre since 1996. I was Vice President of the Association of Ontario Midwives (AOM) from August 1997 to 2001 and President of the AOM from 2001 to 2004. 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.

TABLE OF CONTENTS

1 Curriculum Vitae of Remi Ejiwunmi, AOM0016603.

I. BACKGROUND

1. Education

I graduated with a Bachelor's of Science in Psychology from McMaster University in 1993. I also have a Bachelor's of Health Science in Midwifery from McMaster University, completed in 1996.

3. In 2013 I completed a Masters of Science in Quality Improvement and Patient Safety at the University of Toronto.

4. Towards the end of my Psychology Bachelor's program in 1993, I decided to pursue a specialized health care profession degree and chose midwifery. When I applied to Midwifery I had not realized how competitive it would be to get in. I was one of seven applicants accepted to the McMaster program that year starting in September, 1993. I later found out that hundreds of applicants had been unsuccessful.

5. In my class of seven at McMaster no one had only a high school education. At McMaster, two of the successful applicants had prior nursing degrees, two were practising midwives who had learned through apprenticeships and one had aboriginal midwifery experience. Prior to entering the MEP, I had been on the Dean’s Honours List throughout my Bachelors of Science.

6. A profile of the 1996 Cohort of Applicants to the MEP compared to the 1993 to 1995 cohort noted that “the great majority of the applicants in all four years had at least some post-secondary educational background." [2]

2 Profile of the 1996 Cohort of Applicants to the MEP and a Comparison of the 1993, 1994, 1995, and 1996 Cohorts of Applicants -Report by L.G. Houle and R.W. Pong (January 1997) AOM0009023.

7. I completed what would later be a four-year curriculum in an intensive three years. While this allowed the program to be completed earlier, it resulted in significant challenges related to an inability to earn income as there were very short breaks between consecutive academic semesters and also resulted in long stretches on call as a student during clinical placements with little break in between academic semesters or years. This learning format was similar to the McMaster medical school in which clinical training was based on problem based learning formats (later adopted by Harvard Medical School) and the academic year ran continuously year round without summer breaks which are more typical of routine undergraduate degree programs.

8. In 1996 I started my first year of mentored New Registrant practice. All 71 practicing midwives across the province acted as preceptors for the students.

2. Academic and Clinical Teaching and Presentations

9. I have been an adjunct faculty member at McMaster University since 2012. I am also a non-clinical Adjunct Faculty member at the University of Toronto, Faculty of Medicine, Department of Obstetrics and Gynecology. In 2006 I was a sessional instructor at the Ryerson MEP.

10. I have acted as a clinical Preceptor for midwifery students since 1996.

11. I was also a Reflective Learning Facilitator at Trillium Health Centre from 2004 to 2010. In that role I facilitated reflective learning following high-risk incidents within the Trillium Health Centre.

12. I have presented extensively on midwifery issues as set out in my Curriculum Vitae.

13. I also have co-authored a 2002 peer reviewed journal article "Galactosemia: A Case Study in the Canadian Journal of Midwifery and Research (Vol.1, Issue 2)

3. Clinical Practice

14. I have been a practicing midwife since I graduated from the first MEP class in 1996.

15. I began my midwifery career at Midwifery Care Associates (MCA). The group provided midwifery care to Mississauga, Halton Hills, Brampton and North York Hospitals. I practiced at Midwifery Care Associates from 19960-1999. In 1999, MCA partners dissolved the practice and separated into Midwifery Care of Peel and Halton Hills and Midwifery Care – North Don River Valley. As of 1999 I became a partner at Midwifery Care of Peel and Halton Hills where I continue to practice. There is currently funding for approximately 24 FTE midwives in our practice.

16. We have privileges at Trillium Health Partners, which is the successor hospital resulting from the merger of Trillium Health Centre and Credit Valley Hospital.

4. AOM Roles

17. I have been an active member of the AOM since 1993 when I began as an AOM student Board member. From 1995 to 1998 I sat on the Professional Relations Committee and I have also been Secretary to the Board.

18. I was Vice-President of the AOM for the period from 1997 to 2001 and then President from May 2001 to May 2004.

5. Insurance and Risk Management Roles

19. I have been the Chair of the AOM's Quality, Insurance and Risk Management Program (QIRM) from January of 2007 until January 2016 when I began a maternity leave. (formerly called the Insurance and Risk Management Program) In that role I am active in securing professional liability insurance and managing risk for midwives in Ontario.

20. Prior to taking on the role of chair I was active as a member of the AOM's Risk Management Work Group since 1999. From September 2009 to the present, I have been an active member of the Claims and Risk Management Committee of the Health Insurance Reciprocal of Canada (HIROC), which provides the AOM's professional liability insurance.

21. I facilitate an annual session for graduating students of the Midwifery Education Program on Risk Management. I have been a presenter at the Risk Management in Obstetrical Care Conference on a variety of occasions.

6. Inter-Professional Roles

22. I have acted a Midwifery Representative to the Maternal Newborn Committee of the Canadian College of Family Physicians from April 2002 to May 2004 and in 2006.

23. I have been a member of the Provincial Council for Maternal and Child Health, Low Risk Maternal and Newborn Strategy Leadership Team since July 2015.

24. I have also been part of the BORN Midwifery Advisory Working Group (including BORN Information Systems Enhancements and Clinical Reporting Sub-Committee) since 2014.

25. I am a member of the Mississauga Halton LHIN Regional Maternal Newborn Child Youth Steering Committee.

26. As a member of the GTA-Obstetrics Quality Improvement and Patient Safety Committee (January 2015 to Present) I collaborate with other maternity care

providers including physicians and nurses to make quality improvement recommendations.

II. EXPERIENCES OF STEREOTYPING, PREJUDICE AND DISADVANTAGE

1. Introduction

27. I experienced stereotyping, prejudice and disadvantage as a midwife both pre- and post-regulation. These are highlighted in the AOM Application in this proceeding.

28. Although midwifery has gained much more widespread acceptance and recognition, I experienced considerable resistance. from physicians as a midwife and as the President of the AOM. Stereotypes still persist about midwifery 22 years after regulation.

2. Hospital Barriers

29. I encountered barriers over years to practicing midwifery at our local hospitals.

30. Early on in my career many of my clients elected to go to the Mississauga Hospital because our practice group had the benefit of privileges there. We were not granted privileges at the other hospitals which meant that choosing to give birth there carried the risk of our clients losing access to midwifery led care.

31. Throughout my midwifery career I have dealt with the issue of integrating midwifery into hospitals, including birth capping at hospitals.

32. For a significant period, it was difficult to practice at William Osler Hospital because the administration capped the number of births that midwives could attend. To manage a budget deficit, they did an across the board cut and as a result midwives have a cap. Technically obstetricians were also not allowed to expand their practices but in reality they have to serve women who come in regardless of the cap. As walk-in patients go to doctors they effectively have no cap. As a result, we have been unable to grow sufficiently to meet the demand for midwifery services.

3. Unpaid Work as Midwifery Head

33. In 1996 I began my current position as the Head of the Division of Midwifery within the Department of Obstetrics and Gynecology at Trillium Health Partners. Despite serving as the head of the division since 1996 I was not paid for the role until 2013. Other physician department heads were paid throughout this time.

34. For the first few years there was no formal midwifery head appointed by the Hospital. I was only head because the midwives had decided we needed a representative. There was no formal position.

35. Even once the position became officially recognized it was not compensated. Finally, in June 2013,a new system was implemented where Department Chiefs could select a paid leadership team. The chief was given a budget and could select their own team. The Chief at this time, an obstetrician, decided a midwife would be important to add to the team and as a result the position became formally built into the department and was paid.

4. Inability to Consult with Physicians

36. In 1998 and 1999, the AOM was campaigning for the MOH to revise the OHIP fee codes so that specialist physicians would be paid the same consultation fees for consultations with midwives that specialist physicians received when family physicians consult and make a referral to them. [3]

37. The result of the differential in the fee structure meant that many specialist physicians were refusing to accept consultations directly from midwives and were forcing their clients to make an appointment with their family physician before the specialist would see them.

38. This was not only inconvenient and time consuming for the midwifery client, and created unnecessary expense for the health care system, but it also again reinforced the hierarchical structure of the health care system, where the physicians held the power. This problem was widespread and impacted our midwifery practice.[4]

III. THE FIRST ATTEMPT AT DEVOLUTION AND EMPLOYMENT STATUS DISCUSSIONS

1. AOM Devolution Strategy Group

39. In 1995 as midwives were implementing the new midwifery system and developing their practice group operations, the LMCO raised the issue of devolution which led to the discussion of the employment status of midwives. While midwives were not labelled as employees, neither were we independent contractors. We were referred to as "dependent contractors". We were not interested in a fee for service model, which could erode the midwifery model of care. In response to these issues the AOM created an internal Devolution Strategy Group. I was an active member of this group.

40. During the period from 1994-1997, the AOM and the Ministry had ongoing discussions about the issue of devolution.

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3 AOM Statement Re: problem with Physician Consults with Midwives (Fall, 1998) AOM0002064.

4 Letter to AOM from Community Midwives of Halton re: difficulties in consulting with doctors (1998-08-06) AOM0002063.

2. AOM Survey on Devolution

41. The AOM took steps to seek input from the membership on devolution in 1996 at the regional meetings throughout the fall.[5]

42. In August and September, 1996, Eileen Hutton and I conducted a survey of all the Midwifery Practice Groups. We asked where their practice groups were in the process of devolution, and their opinions about exploring employer-employee relationships with TPAs.[6] Out of the 26 who received it, 21 practices responded to the survey. These results were published on September 20, 1996.[7]

43. Notably, the summary of findings from practice groups yielded that 95% of those surveyed disagreed with exploring employer-employee relationships with the identified TPAs and 91% agreed with maintaining a contract relationship with the LMCO.[8]

44. The survey identified six principles which the membership unanimously supported:

- Following devolution midwives will continue to provide care in the Ontario Model of Midwifery Care;
- Following devolution midwives will continue to provide care in autonomous group practices;
- Following devolution midwives will continue to work in a contract model of compensation as set out in the Framework Document and the Funding Agreement which is consistent across the province;
- Devolution to local transfer payment agencies will ensure effective consumer involvement at the community level in order to protect the unique features of the model of midwifery care in Ontario. The best mechanisms for involving consumers should be determined by consumers at the community level; and
- Practices will have the ability to participate in Primary Care Reform in appropriate ways, including involvement in primary health care agencies. [9]

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5 List by AOM re: Items to Include in Regional Meetings (September 1, 1996) AOM0008135.

6 Funding Committee Meeting Agenda and attachments for Sept. 18, 1996, AOM0002394.

7 AOM Survey on Devolution Summary Results (September 20, 1996) AOM0008048.

8 AOM Survey on Devolution -Summary of Results - prepared for the AOM Funding Committee by R. Ejiwunmi and E. Hutton (October 1996) AOM0001123 at p 4.

9 AOM Survey on Devolution -Summary of Results - prepared for the AOM Funding Committee by R. Ejiwunmi and E. Hutton (October 1996) AOM0001123.

3. AOM Consensus Building Session on Devolution in October 1996

45. Following the survey, the AOM held a consensus building session on October 24, 1996. This resulted in a November, 1996 Draft Report on Consensus Building Session on Devolution which highlighted the AOM membership's concerns with the process. [10]

IV. THE PAUSE AND RESUMPTION OF DEVOLUTION NEGOTIATIONS

46. In August 1997, the AOM finalized its report on devolution entitled "Towards More Integrated, Cost-Effective Midwifery in Ontario"[11] which was developed following the above-noted consensus building process to guide the ultimate AOM-MOHLTC discussions. We knew that the MOHLTC was very concerned about the liability the MOHTLC and local TPAs might have to midwives if they were construed to be employers of midwives. At the same time, we wanted to make sure that any independent contractor devolved arrangements supported a quality model of care, including full caseload defined as 40 courses of care, supporting group practice, growth of the profession, choice for women, and continued quality and safety.[12]

47. As Carol Cameron was to go on maternity leave in November of 1997, Bridget Lynch began her presidential term early. I resigned from the position of secretary and was appointed "President-elect/Vice President" in the fall of 1997. [13]

48. After a time on hold, negotiations resumed in the fall of 1997. AOM President Bridget Lynch and myself as Vice President along with AOM representatives Wendy Katherine and Elana Johnson engaged in these discussions as the AOM's Devolution Strategy Team with the LMCO and the Ministry. The AOM's Professional Relations Committee, headed by Wendy Katherine and myself were also involved in these discussions.

49. Throughout the negotiations in 1997 and early 1998, midwives understood that the government wanted to move to an "independent contractor" relationship, to avoid the TPAs having employer obligations. However, it was not until June, 1998, that the CHB, having sought a second legal opinion, decided it needed to

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10 AOM Survey on Devolution -Summary of Results - prepared for the AOM Funding Committee by R. Ejiwunmi and E. Hutton (October 1996) AOM0001123.

11 Letter from Carol Cameron, President, AOM to Bonnie Heath, Coordinator, OMP enclosing Towards More Integrated, Cost-Effective Midwifery Care in Ontario (1997-08-29) MOH003939.

12 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, (July 5, 1997), AOM0003750.

13 Executive Report submitted by Carol Cameron, Liz Darling and Remi Ejiwunmi re Devolution, AGIP, Presidential [Presidential] Nominations and Staffing (September 19, 1997) AOM0014237.

make drastic changes to the midwives' funding agreement in order to preserve that status.

50. In late March 1998, the LMCO would cease to exist, but the local Transfer Payment Agencies which would replace it had not yet been set up because of the delays in the creation of the new contract. As a result, on March 31, 1998, midwifery practice groups entered into an interim TPA agreement with the Lawrence Heights Community Health Centre (LHCHC) which had taken over from the LMCO in the capacity of an Interim Trustee.

V. FOCUS ON AVOIDING LOSS TO COMPENSATION OR MODEL OF CARE THROUGHOUT DEVOLUTION

51. During these negotiations, the AOM worked to ensure that the overall compensation which midwives would receive from the Ministry remained comparable to our compensation under the pre-existing “salary” regime. The MOHTLC was not willing to discuss any increase in compensation. Their mandate was to devolve the system while ensuring an independent contractor status for midwives. The process was extremely lengthy and complicated.

52. During the devolution process we were particularly concerned about ensuring the move to a "course of care model" would not cause an increase in unpaid work by midwives. At the time people were used to getting 1/12 of their global compensation every month- the notion of switching to courses of care paid only once all care was completed and the client was discharged from care was brand new to midwives. It raised many new concerns. For example, we were concerned about "partial courses of care" – for example, if someone had a miscarriage.

53. There was a substantial increase in work required of midwives by the new independent contractor relationship, including substantially enhanced practice management and reporting responsibilities. As no separate funding was provided for the transition responsibilities, during this period midwives had to absorb the costs of the process which resulted in unpaid work.

VI. MIDWIFERY SYMPOSIUM ON MIDWIFERY MODEL OF CARE (MAY 2001)

54. I took over presidency of the AOM in May of 2001. During that time, I was also on a collaborative Conference Committee along with Bridget Lynch, Vicki Van Wagner and Robin Kilpatrick (Registrar of the CMO). Together we organized a Symposium working with the CMO and MEP, which took place on June 4-6, 2001 on the Model of Midwifery Care in Ontario.

55. The Minister of Health Tony Clement spoke at that conference. His “Minister Remarks to Participants” referred to the great benefits and value of midwifery service in Ontario.[14]

56. During the question and answer period AOM midwife Carol Cameron asked the Minister about the insurance crisis which had developed as a result of rising medical malpractice costs which was causing midwifery malpractice premiums to increase dramatically.[15] "our premium policy does expire in less than 2 months on July 31st, so when will the midwives hear that the government is committed to continuing to fund these premiums?" The Minister replied: "what I want to do is look at some of the alternatives … I will have to talk to some of my cabinet colleagues because some of the models involve the province taking a more active role but I am committed to raise that issue and I am aware of the time sensitivity." [16]

VII. RESOLVING THE INSURANCE CRISIS

57. On June 19, 2001 I wrote to the Minister saying, that "AOM members were especially excited to hear your support for funding the increase in liability insurance premium costs for midwives this year." [17] I asked him for a clear commitment given the short time lines.

58. With no response from the Minister's office, the AOM sent a more urgent letter on July 9 2001:

the increase in liability insurance premium costs for this year for midwives in Ontario, and the funding for those premiums remains unresolved … we have not received confirmation of the Ministry's decision to fund insurance premiums for midwives yet. We have increasing concerns about the rapidly approaching deadline of July 31, 2001 to hear from the Ministry on this issue. to date, the hard work of the Ontario Midwifery Program has not yet resulted in approval for the expenditure of these funds. We urgently request that you meet with us so that the solution you spoke of can be reached before midwives in Ontario are unable to practice because they do not have liability insurance/ [18]

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14 Minister's Remarks at the AOM's Symposium on the Model of Midwifery Care in Ontario (2001-06-05) MOH022136.

15 Globe and Mail Article: Ontario medical malpractice costs to soar, (February 17, 2000), AOM0016475.

16 Question and Answer Period with Minister Clement at the AOM Symposium on the Midwifery Model of Care (2001-06-05) MOH022137.

17 Letter from Remi Ejiwunmi, President, AOM to Tony Clement, Minister of Health re comp and other issues (2001-06-19) AOM0010399.

18 Letter from Karen MacLeod, Vice-President, AOM to Tony Clement, Minister of Health and Long-Term Care re response re funding increase professional liability insurance premiums (2001-07-090) AOM0010398.

59. On July 26, 2001 we wrote the Ministry of Health once again, stating that "the amount remaining due for the period July 31, 2001 to May 31, 2002 is $17, 477.78. This was the amount owing for each midwife. We continue to await a letter from the MOHLTC confirming this funding" [19]

60. Finally on July 27, 2001 the Minister approved funding for renewal of midwives' professional liability insurance premiums for the year.[20] Everyone, including the MOHLTC treated this issue as a rising expense of providing midwifery services – not as increased compensation for midwives.

61. As a result of the efforts of midwife Bobbi Soderstrom, the professional liability insurance policy for midwives was transferred from ENCON Insurance Managers Inc to the Health Insurance Reciprocal of Canada (HIROC) on June 1, 2003.[21]

VIII. ONGOING ISSUES RELATING TO CONSULTATION FEES FOR SPECIALISTS

1. Introduction

62. The CMO's regulations have required midwives to make consultations and transfers of care since the regulation of midwifery. As early as 1994 the AOM and consumers had identified the need to create a payment mechanism to allow physicians receiving midwifery initiated consultation requests to be paid a fee for those specific services. As midwifery was approaching proclamation as a registered health profession, we were told that discussions took place between the OMA and MOH regarding the funded access of specialists by midwives. At that time, the MOH indicated to us that they intended to change the legislation to facilitate physician payment for midwifery consultation.

63. In the spring of 1994, however, after the social contract agreement was signed which restricted physician billings, the OMA refused to allow the changes which would have enacted reimbursement for direct midwife referral. The OMA Executive Council rejected legislative modification, unless additional funds be provided for accepting midwife initiated consultation, outside the OHIP pool. It was our understanding that MOH maintained that introducing midwives was already saving OHIP money, since the cost of client care was outside the pool, and refused to bargain with the OMA on that issue.

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19 2001/07/26 Letter from Alison Dantas, Executive Director, AOM to Wendy Katherine, Co-ordinator, OMP (2001-07-26) AOM0010393.

20 Letter from Tony Clement, Minister of Health and Long-Term Care to Remi Ejiwunmi, President, AOM re: $6,100,000 enhancement to OMP for new grads and $3,200,000 for renewal of professional liability insurance premiums (2001-07-27) AOM0010394.

21 MOHLTC memorandum to TPAs re: Midwifery Liability Insurance Refunds (2003-11-24) MOH020688.

64. As a result, consultation fees were payable to physicians only if the request for consultation was received in writing from another physician. This is an example of the dominance of physicians and the OMA in the maternity care system and also the unnecessary costs arising from such dominance. It fell to the AOM a small fledgling profession of women to advocate on behalf of getting physicians more money so that they would accept our referrals and our clients would not be inconvenience by having to go see their family physician to get the referral.

65. After years of efforts by the AOM, in 1999, two new fee codes were introduced to provide remuneration to specialist physicians for "emergency" in-hospital midwifery-requested consultations only. However, the AOM was not informed of this change. This still did not cover non-emergency referrals.

66. In 2000, the Auditor General's Report on the OMP commented on the issue as follows:

67. "The current referral practice may create additional costs for the health care system and inconvenience women and their children, such as requiring them to make unnecessary visits to family physicians and hospital emergency wards." [22]In an email dated July 9, 2001, Wendy Katherine (now at the Ministry as the OMP Coordinator) had updated me regarding the amendments to the fee codes which were introduced in 1999.[23]

68. In October, 2001 we prepared a policy brief on this issue which was provided to the MOHLTC: "Consultation Fees for Midwife to Specialist Referrals", (October 24, 2001).[24]

69. However, as of 2001, there was still no mechanism for physicians to be compensated for out-patient and non-emergency midwifery requested consultations. Such referrals resulted in physicians having to bill for the lower paying assessment fee code rather than the higher paying consultation fee code and most specialists, as a result, refused to take direct midwifery non-emergency consultations without the client going back to their family physician for the referral.

IX. ONGOING INTER-PROFESSIONAL LACK OF COLLABORATION

1. Stalker Inquest

70. During my time as the AOM President there was major public interest in the death of an infant (Eoin Stalker) where a physician refused to let a midwifery

22 Auditor General Annual Report 2000. Cite: Provincial Auditor Report, Ontario Midwifery Program, (January 1, 2000) AOM0016543 at p. 205.

23 Internal AOM email re: Consultation fees for specialists from Wendy Katherine, OMP (2001-07-0) AOM0010221.

24 Consultation Fees for Midwife to Specialist Referrals, (October 24, 2001), AOM0010146.

client who was in distress and required a transfer into hospital to be admitted. The midwife had to drive the client to another hospital, by which point, the infant later died from lung complications on May 20, 2000. An inquest was called to investigate whether the alleged refusal of care by the obstetrician was a unique incident or an indication of systemic conflict between midwives and other health care professionals.

71. In December 2001 the Coroner's Jury verdict and recommendations from the inquest into the death of Eoin Stalker were released.[25] The jury called for improved communication amongst obstetrical providers, the need for removing systemic barriers for better integration of midwives into hospital settings and the removal of barriers to effective care.

72. While the recommendations regarding inter-professional collaboration were welcomed, it was disheartening that they needed to be made as we had been making so many efforts to improve collaboration with obstetricians.

73. On behalf of the AOM I advocated for the inquest to investigate the issue of funding and how it was impacting the relationship between midwives and specialists. As the AOM President, I was quoted in the *Guelph Mercury* in November of 2001 saying, "a major funding issue affecting integration of midwives in the health care system is that obstetricians get a lower fee if they provide consulting services to midwives than they can bill OHIP for consulting with physicians … The impact varies from hospital to hospital, but in non-emergency cases midwives have been refused consultations, and their patients forced to go through family doctors to get obstetrical assistance."

74. AOM members updated us on an ongoing basis about this serious issue. For example, in August 2001 we became aware of a physician refusing to treat a patient for the patient's hypothyroidism while the patient was in midwifery care.[26] These kinds of incidents were too frequent.

2. Ongoing Failure to Address Equal Fee Codes for Specialists on Midwifery Direct Referrals

75. In October 2001 the AOM's Professional Relations Committee conducted a survey with midwives about how they were affected by physicians not having fees for consults with midwives. Out of a possible 26 Ontario midwifery practices, a total of 23 (88.5%) responses were received. Of the practices who responded, a total of 15 (65.2%) had been adversely affected by the OMA policy: 9 (39.1%) gave a negative only response, 6 (26.1%) gave both a yes and no answer to the

25 Coroner's Jury Verdict and Recommendation, re: Inquest into the Death of Eoin Stalker (December 1 2001) AOM0015516; Letter to AOM from Health Minister re. physician consultant fees (January 1, 2002 est) AOM0001325; Verdict Explanation by K. Acheson (Presiding Coroner) re: Inquest Into the Death of Eoin Stalker, (January 1, 2002), AOM0005952.

26 Letter from Diane Parkin to a Physician re: Denial of Care (2001/08/24) AOM0011222.

question. A total of 8 practices (34.8%) felt that care had been compromised, while an equal number reported no problems with the policy. In short, a majority of Ontario midwives report experiencing negative impact resulting from the current OMA policy. A third of Ontario midwifery practices reported compromised client care.[27]

76. On October 31, 2001, I wrote to Tony Clement, Minister of Health and Long Term Care to follow up on this issue of midwifery consultation fees. I described the initial AOM's understanding that the Physicians Services Committee had established a multi-stakeholder group with the MOHLTC, the AOM and the OMA which was to develop a proposal to resolve the fee code issue. I then expressed my disappointment that no progress had been made on establishing such a group or proposal. The letter highlighted as quoted below the issues and urgency of the need to resolve the issue:

"This issue has obstructed the full development of the practice of midwifery since its introduction in this province in 1994. The lack of such codes has prevented midwives from being fully integrated into the health care team in some parts of Ontario. We believe that such integration is critical to the efficient and cost efficient provision of health care to the mothers of Ontario and their newborn children, particularly in light of the recent report detailing the current and projected shortfall of family physicians. In addition, we believe that the issue of consultation fees, as they relate to relationships between midwives and physicians, may be one of the issues surfaced at the Coroner's Inquest in the death of Baby Eoin Stalker that is currently underway in Guelph."

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In light of the eight years that we have been attempting to resolve the matter of midwife consultation fee codes, and in light of the 2000 Report of the Auditor General of Ontario, which includes the following recommendation "The Ministry should ensure that the current process for referring clients of midwives to specialists does not result in unnecessary visits to family physicians or hospital emergency departments." [28]

77. In May of 2002 the Ministry finally added new OHIP fee codes for non-emergency consultations of midwives with specialist which provided the same fees for specialists whether they received referral from midwife or family physician. [29] [30]

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27 Summary by AOM's Professional Relations Committee Survey re: OMA Consultation Fee Policy for Specialists (2001-10-24) AOM0010148.

28 Letter from R Ejiwunmi (AOM) to Minister of Health and Long Term Care, Tony Clement re: midwifery consultation fee codes (2001/10/31) AOM0007916.

29 Email from A. Dantas to R. Ejiwunmi forwarding Email from W. Katherine dated May 15, 2002 re: Physician Consult Fees attaching letter from T. Clement (Minister of Health) (2002-05-15)

3. Hospital Integration Survey

78. The Stalker Inquest jury recommended that the government participate with midwifery and medical stakeholders to strengthen the understanding of consultation, transfer of care, communications and documentation issues.

79. On December 13, 2001 I wrote to Minister Clement to follow up on this recommendation. He responded: "while you can count on the active participation of ministry staff in a study of this issue, I would encourage your association to work with the Ontario Medical Association and the colleges of both professions to lead the process to ensure the study is conducted by those most closely associated with professional practice. I look forward to being kept up to date on how the study is progressing." [31]

80. In March 2002 the AOM executive wrote to the OMP proposing that the OMP fund a comprehensive Hospital Integration plan based on recommendations from 2001 Stalker inquest.[32] There was not any action on this request later with the Healthforce Ontario Project.

81. With no direction from the OMP, the AOM took on the task of structuring research into these issues. The AOM's Hospital Relationships Task Force designed a survey in April of 2002. We prepared questions designed to find out the types of issues causing problems between midwives and doctors in hospitals.

82. In November 2002 the MOHLTC reviewed the document but the AOM and the MOHLTC were unable to agree on the design of the survey. Ultimately the survey was conducted as part of the OMP's program evaluation in 2003, with a mix of questions developed by the AOM and by the MOHLTC.

83. As the survey was based on the work of the AOM's Hospital Relationships Task Force and included many questions developed by the AOM, the OMP agreed to share the results of the AOM. Those survey results were developed into the *Report on the Results of the Midwifery Practice Group Hospital Integration Survey, 2003.* That report was used to support advocacy work with the MOHLTC,

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AOM0010150 Report by MOH re: Special Report on Accountability and Value for Money: Ontario Midwifery Program, (January 1, 2002), AOM0000826.

30 Report by MOH re: Special Report on Accountability and Value for Money: Ontario Midwifery Program, (January 1, 2002), AOM0000826.

31 Undated letter from Tony Clement, Minist0er of Health and Long-Term Care to Remi Ejiwunmi, President, AOM re: Response to Ejiwunmi's letter dated December 13, 2001 re: Jury Recommendations in Stalker Inquest and re specialists fees (2002, est) MOH000440.

32 AOM Proposal to OMP Hospital Relations (2002-03-25) AOM0002100.

the OHA and other professions to engage them in assisting midwives to obtain privileges.[33]

84. It was distressing to see in these survey results persistent challenges with midwifery integration, nine years after the regulation of the profession. It was also disturbing to see comments like: "OMA policy to not reimburse consultations provided some challenges" (p. 5) "37% of Midwives said their clients were required to go through different processes than other health care professionals." (p. 8). "Will be under the supervision of OBs until I learn to twist, pull and yank on all babies heads immediately after the head deliveries." (p. 5) and "obstetricians at her hospital were still angry about receiving lower fees for consult (?) she said she feels 'like a battered woman' (p. 8). [34]

85. In a 2003 document authored by the AOM Benefits Trust, hostile relationships with physicians is included as a cause of stress" "Local communities, doctors and hospitals vary widely throughout the province in terms of the level of acceptance toward midwives and midwifery. This can be a significant factor affecting working conditions and stress levels for midwives." [35]

86. As well, the AOM commissioned a further 2004 survey, which resulted in, the May 1, 2004 Report by ABS System Consultants re: Hospital Integration Survey which highlighted the continuing inequitable treatment of midwives in hospitals.[36]

X. ONGOING MOHLTC BUDGETING AND FUNDING ISSUES

1. Unilateral MOHLTC Decision Regarding Insurance For New Registrants

87. On January 22, 2002, I received a letter from the OMP's Wendy Katherine notifying me that the Ministry had unilaterally decided that it would not provide malpractice liability insurance during in the 2002-2003 fiscal year for midwives unless they were registered and approved before March 31, 2002. The MEP graduates complete their degree in April of each year. The result of the decision was that the entire graduating class of New Registrants at all three universities

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33 Report on the Results of the Midwifery Practice Group Hospital Integration Survey, 2003.Can't find the Relativity doc but found a prelim report: Hospital Integration Survey Preliminary Findings(January 17, 1994), AOM0005943.

34 Report on the Results of the Midwifery Practice Group Hospital Integration Survey, 2003.Can't find the Relativity doc but found a prelim report: Hospital Integration Survey Preliminary Findings(January 17, 1994), AOM0005943.

35 Document from AOM Benefits Trust re: Ontario Midwife Job Description in Relation to Disability Coverage, (January 1, 2003) AOM0001144 at p. 2.

36 2004 Report by ABS System Consultants for AOM re: Hospital Integration Survey, (May 1, 2004), AOM0005944 and in particular pp. 8- 9.

could not meet the requirement. [37] This caused swift and high anxiety within the midwifery sector especially to the young women about to graduate.[38] [39]

88. On February 22, 2002 I wrote to Minister Clement requesting that Ministry remedy the serious problem with the regard to the timing of funding for New Registrants.[40] I noted that we had raised this issue with the Ministry repeatedly and that the delayed funding makes growth impossible because practice groups are left in a position of being restricted from contracting graduates until six months following the date of their graduation, when budget approval for the fiscal year was provided. As a result pregnant women seeking care were left without midwifery care despite both demand and the existence of training registered midwives. I noted the serious attrition issue this caused, "new graduates who are training and registered midwives and who are unable to work due to the lack of budget approvals are leaving the province to work elsewhere because they can begin work immediately. Practice groups are left with an ever increasing demand for midwifery care …" I noted that we had been reliably informed that as many as 30% of Ontario new registrants were seeking work elsewhere.

89. The AOM also continued to object to the Ministry's late approval of budgets often not until November of each year, 8 months into the ministry's fiscal year, long after the MPGs needed to make decisions about taking on midwifery clients and noting the impact on the ability of MPGs to take on new registrants.

90. On March 5, 2002 Kristy Hook, Member of the AOM Executive Committee sent another letter to the minister asking for a response to our February 22 letter.[41]

91. On March 14, 2002 we met with MOHLTC officials to discuss this issue.[42] At that meeting the OMP's Wendy Katherine informed us that approval for New Registrants would not be possible because of the sharp increase in insurance costs in 2001. We pointed out that all medical practitioners were subject to similar increases due to changes in the external insurance markets. While the Ministry expressed concern about the attrition of midwives, it took the position they were unable to assist the 40 new midwives who were graduating in six weeks, despite the fact that midwifery is a "managed program" of the ministry. We alerted the Ministry to the fact that we were considering a public campaign in support of new registrants. The public campaign was actually to march on

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37 Memo from AOM to Members re Insurance Funding Crisis (2002-02-06) AOM0002105 at p. 1.

38 Memo from AOM to Members re Insurance Funding Crisis, (February 18, 2002), AOM0002106.

39 Letter from Sandra Kittel, Midwifery Care of Peel & Halton Hills to Tony Clement, Minister of Health and Long-Term Care, (March 7, 2002), AOM0010883.

40 Letter from Remi Ejiwunmi, President, AOM to Tony Clement, Minister of Health and Long-Term Care re New Registrant and Professional Liability Insurance issues (2002-02-22) AOM0010373.

41 Letter from Kristy Hook, Executive Committee Member, AOM to Tony Clement, Minister of Health and Long-Term Care, (March 5, 2002), AOM0010881.

42 AOM Agenda & Notes of Mtg with Health Minister's Office (2002-03-14) AOM0002107.

Queen's Park which we ultimately ended up doing and which was the only reason we were finally responded to.

92. The following day I wrote to the MOHLTC to follow up from this meeting: "we believe that resolving the issues under discussion is fundamental to the sustainability of the profession and it is wrong to assume that this is a long term planning problem. The repercussions of the Ministry's unilateral decision to change the funding process not only challenges our trust that we work in partnership to resolve difficult problems, it challenges the understanding that we all shared about the funding contract." [43]

93. By letter dated March 18, 2002, Minister Clement responded to me and stated that there was assured funding for new registrant midwives graduating from the MEP in 2002.[44] I believe this reversal of position was a direct response to the public protests organized by the AOM (We marched on Queen's Park and they came out with a letter just as we were about to start our press conference. I believe this is the only reason they responded). I found it very upsetting that the Ministry was not willing to act on a straight forward program management issue without the threat and action of public pressure.

2. Budget Approval Cycle

94. In addition to the insurance crisis, the AOM was also trying to resolve the issues caused by the Ministry's budget request and approval cycles, which caused significant adverse impacts for midwives and their clients.

95. All forms of compensation paid to the practice group (fees, disbursements, grants) are applied for on an annual basis by the practice group submitting a budget request to the TPA who then forwards them onto the OMP**.** During the annual budget application process the practice group must apply for the maximum allowable amount of fees, disbursements and grants they will require in the upcoming year. Once the budget is approved by the Ministry, the practice group is bound by the confines of the approved budget until the application process happens again the following year.

96. The timeline for the annual budget cycle was as follows:

- Practice groups must submit a budget for approval to their TPA by the first week of January, for the fiscal year starting in April. (For example, in January 2002 women with due dates in August 2002 were calling for care)

43 Letter from R. Ejiwunmi to Ni. Offord (Senior Policy Advisor, MOH) re: Insurance and Funding (2002-03-15) AOM0010139.

44 Letter from Tony Clement, Minister of Health to Remi Ejiwunmi, President, AOM responding to Ejiwunmi letter re: funding for new registrants (2002-03-18) AOM0010368.

- The budget is reviewed by the TPA and submitted to the Ontario Midwifery Program within the Community Health Branch of the Ministry in March of each year (by which point women with due dates in October 2002 were calling for care)

- The Ministry budget does not get its budget approval until the late summer or early fall each year. (At which point women with due dates in March of 2003 (the last month of the fiscal year for which approval is being provided were calling for care)

- The Ministry reviews midwifery practice group budgets based on their overall budget approval and submits approved budgets to the TPAs across the province.

- Historically, budget approvals have come at any point between June and November .

97. In his letter of March 22, 2002, Minister Clement stated that "we will continue to work toward a long-term resolution for budget planning." [45] In reality the budgeting issues have only become worse. There have been years in which the budget approvals have come as late as November, at which point women calling for care are actually billable in the subsequent fiscal year. The fact that MPGs are beholden to their last approved budget until a new one is approved has meant that even though there are new graduates and capacity for growth, MPGs have held their intake at the approval levels for their last budget. This entire budget approval process has been a constant problems for MPGs.

XI. HIGH DEMAND FOR MIDWIFERY AND SHORTAGE OF MIDWIVES: THE OBSTETRICAL CRISIS

98. The large unmet demand for midwives and the shortage of midwives to meet that demand, as well the ongoing attrition and retention issues has been a major issue throughout my career as a midwife.

99. In the early 2000s, a working group of the Association of Ontario Midwives, the College of Midwives of Ontario and the Midwifery Education Program had identified a maternity care provider crisis. The group noted "an imminent shortage of obstetricians due to retirement of a vast number of older obstetricians combined with low numbers of obstetric specialists currently graduating from medical schools." [46] This problem had also been identified by the 1999

45 Letter from Tony Clement, Minister of Health to Remi Ejiwunmi, President, AOM responding to Ejiwunmi letter re: funding for new registrants (2002-03-18) AOM0010368.

46 Report by B. Lynch, AOM: Review of Model of Midwifery Care in Ontario Seven Years Following Regulation (2001-09-01) AOM0006542.

"McKendry Report" [47] on physician resources in Ontario which identified this issue in smaller communities, and the Report of the Expert Panel on Health Professional Human Resources (2000).[48]

100. In his March 2002 speech to the Ontario Society of Obstetricians and Gynaecologists George Smitherman, later replacing Clement as the Minister of Health in 2003, outlined inequalities in women's health and discusses maternity crisis that is, the declining number of maternal care providers. He spoke about need for a maternity care strategy and the development of the Ontario Maternity Care Expert Panel. [49]

XII. AOM EFFORTS TO OBTAIN EQUITABLE COMPENSATION AND FUNDING

1. Introduction

101. When I began my presidency, the compensation for midwives had not increased since it was originally set in 1993. Our efforts to get the Ministry to address the issue had been unsuccessful.

102. In 2000 and 2001, the AOM had made requests to the Ministry that steps needed to be taken to address the frozen compensation of midwives since 1994, including a request for adjustments back to 1994.[50] [51] [52] [53] [54] The OMP had responded by stating that there was no money in the budget for a compensation increase.[55] However, Sue Davey had indicated in a meeting in late January

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47 Report of the Fact Finder on Physician Resources in Ontario by Dr. Robert McKendry titled Too Many? Too Few? For 2000 and Beyond December 1, 1999, (December 1, 1999) AOM0014610 at p. 47.

48 Shaping Ontario's Physician Workforce: Building Ontario's Capacity to Plan, Educate, Recruit and Retain Physicians to Meet Health Needs. Report of the Expert Panel on Health Professional Human Resources (2001) AOM0017411.

49 Speaking Notes for George Smitherman at Ontario Society of Obstetricians and Gynaecologists (March 21, 2002) AOM0002414.

50 Letter from AOM to Sue Davey re: cost of living adjustments and Inflation (November 1) AOM0000672.

51 Letter from Alison Dantas, AOM to Wendy Katherine, OMP re: Compensation Adjustment Date (November 17, 2000) AOM0010357.

52 Letter from Bridget Lynch, President, AOM to Sue Davey, Co-ordinator, Community Health and Promotion Branch Re: COLA and Inflation (December 15, 2000) AOM0010352.

53 Letter from Bridget Lynch, President, AOM to Sue Davey, Coordinator, Community Health and Promotion Branch (January 9, 2001) AOM0010351.

54 Lynch letter re declining to increase compensation, travel or other grants (January 10, 2001) AOM0002036.

55 Letter from MOH Sue Davey to AOM Bridget Lynch responding to AOM November 1, 2000, December 15, 2000 and January 9, 2001 Lynch letters declining to increase compensation, travel or other grants (2001-01-10) AOM0002036.

2001 with the AOM that the Ministry would review the issue in September 2001 but no review happened.

103. On June 19, 2001, when I wrote to Minister Clement following up on his statements at the Symposium I requested to meet with him on several different issues, including to "develop a strategy to address the compensation scale for midwives as rates have not been increased since the Midwifery Program began funding practitioners in 1994."[56]

104. In Minister Clement's letter dated July 27, 2001 (where the MOHLTC agreed to fund the increased insurance premium) there was no reference to any increase in compensation for midwives and no reason given for declining to address the case made by the AOM for equitable compensation and funding including a cost of living adjustment.[57]

105. Further, despite the concerns we had raised about the impact of delays in budget approval, that year, the Ministry did not send out the approved budgets until October 2001. This again caused undue stress and destabilization throughout he midwifery sector.

106. In speaking to our members across the Province at our 2002 Fall Regional Meetings there was consensus that compensation for midwives had to be addressed by the AOM in 2003. The AOM Board took that input and prioritized compensation as the #1 issue that had to be addressed in 2003.[58]

2. Advocating for the MOHLTC To Do Compensation Review

107. There had been no compensation review carried out by the MOHLTC since the 1993 Joint Funding Work Group negotiations and the July 26, 1993 Morton report.[59] The compensation for midwives had been frozen since that date. No further analysis had been undertaken by the MOHLTC to analyze changes to the skill, effort, responsibility and working conditions of midwives since the analysis in July 1993 and comparing that to the work and pay of the CHC physician and the nurse practitioner. There were no formal processes or procedures that the AOM could access to have the Ministry address the compensation issues. There did not appear at the time to us to be any specific policies that compelled the

56 Letter from Remi Ejiwunmi, President, AOM to Tony Clement, Minister of Health re comp and other issues (2001-06-19) AOM0010399.

57 Letter from Tony Clement, Minister of Health and Long-Term Care to Remi Ejiwunmi, President, AOM re: $6,100,000 enhancement to OMP for new grads and $3,200,000 for renewal of professional liability insurance premiums (2001-07-27) AOM0010394.

58 AOM AGM Presenters Notes re: various issues including Presentation by Hay's Moshe Greengarten re: Compensation Review and Hay Report (June 2003) AOM0002194.

59 "Compensation for Midwives in Ontario" Summary Report Prepared for the Midwifery Funding Work Group by Robert Morton and Associates (July 26, 1993) AOM0007183.

ministry to periodically review or compensation even though midwifery was a "managed profession".

108. By the early 2000s the AOM was aware that the Association of Ontario Health Centers had retained the Hay Healthcare Group in conjunction with the MOHLTC to do compensation survey in 1999 that cost them $70,000, paid for by the MOHLTC.[60]

109. At the Annual Meeting and Symposium in June 2001, Minister Clement when the issue of our frozen compensation had been raised, told us that other groups were in line ahead of midwives to have compensation issues addressed and that he would consider a compensation review for midwives in the subsequent year.[61] When we raised the issue again in March of the following year, just after the New Registrant Funding issue was resolved we were told it could not be addressed then.

110. In 2002 we requested from the OMP that a compensation review be carried out but were informed that the MOHLTC would not cover the cost. In an informal conversation the OMP's Wendy Katherine had suggested that it would be a good idea to do one in tandem with the OMP program evaluation which was required by the zero budget policy.

111. By letter dated December 9, 2002, I wrote to Minister Clement respecting the promise he made at the June 2001 Symposium that there would be a compensation review.[62] In my letter I stated that the AOM had seen nurses, nurse practitioners and Community Health Centres successfully obtain changes to their compensation. I expressed concern over the Minister's remarks at the June 2001 symposium that other groups were in line ahead of the midwives to have compensation issues addressed. I requested a compensation review process to take place for midwifery in 2003.[63]

112. On behalf of the Minister, the OMP's Wendy Katherine wrote back to me stating the Ministry had already factored midwifery services into the government's budget.(which would have been at the frozen rate). She further stated that she looked forward to working with me on the compensation issues raised in the

60 Draft Minutes of AOM Executive Committee Meeting (2002/08/13) AOM0002110.

61 Minutes of AOM Executive Meeting.doc, (March 19, 2002), AOM0002109.

62 Letter from Remi Ejiwunmi, President, AOM to Tony Clement, Minister of Health re compensation review and increase (2002-12-09) AOM0010342.

63 Letter from Remi Ejiwunmi, President, AOM to Tony Clement, Minister of Health re compensation review and increase (2002-12-09) AOM0010342.

December letter and that Ministry staff had already contacted the AOM Executive Director.[64]

113. In early 2003 we received a vague response to our request to address compensation issues. In the letter the Minister acknowledges awareness of compensation issues raised by AOM.[65] In February of 2003 we received a letter from Premier Ernie Eves thanking midwives for our excellent service but not responding to any of the issues we had raised.[66]

114. At this time, we were also engaged with the MOHLTC on the OMP Program Evaluation. We were later told by the Ministry as set out below that the compensation discussions would need to await the completion of the OMP program evaluation.

115. At the April 23, 2003 meeting, the Ministry showed their "program logic model" for midwifery which showed their direct link from Human resources planning and Integration of midwives to improving maternal and child outcomes.[67]

3. AOM Retaining the Hay Health Care Group

116. In August 2002 we started taking steps towards the possibility of conducting our own compensation review. We assigned an AOM staff member to review the 1993 Joint Funding Work Group discussions, documentation and the July, 1993 Morton Report study with an emphasis on the appropriate comparators for midwives.

117. In light of the above refusal of the MOHLTC to address our compensation concerns and request for a compensation review, the AOM decided to retain an independent third party to investigate and provide a report which could be provided them to the MOHLTC to support the AOM's request for equitable compensation.

118. We decided to send the Request for Proposal to six companies who had done compensation reviews for other MOHLTC funded programs.[68]

119. In the Request for Proposal[69] we wrote that, "our goal is to conduct a compensation review that:

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64 Unsigned Letter from Wendy Katherine to Remi Ejiwunmi re: security of midwifery funding (2002-12-30) MOH020727.

65 Unsigned letter from Tony Clement, Minister of Health and Long-Term Care to Remi Ejiwunmi (2003 est) AOM0010344.

66 Letter from E. Eves to R. Ejiwunmi and A. Dantas re: midwifery in Ontario (2003-02-24) AOM0002131.

67 Midwifery Program Logic Model, (April 23, 2003), AOM0014067.

68 Minutes from AOM Board Meeting (2003/01/22) AOM0002181.

(a) Identifies appropriate comparators for compensation for Ontario midwives

(b) Reviews the midwifery fee, the operations fee, and the portion of compensation that is equivalent to 16% of the midwifery fee, which midwives direct into the AOM Benefits Program;

(c) Develops recommendations for the AOM as to what level of compensation would be fair market value for midwives in Ontario (in all 3 categories listed in point b. above) 10 years after the establishment of the current compensation schedule.

(d) Recommends a compensation scale that would be appropriate, including a mechanism for how Ontario midwives migrate up the scale over time.

(e) Recommends the appropriate % amount of the midwifery fee to ensure the ongoing sustainability of the AOM Benefits Program;

(f) Recommends the operation fee that would be most appropriate to ensure the ongoing sustainability of midwifery practice groups; and

(g) Comments on the need for COLA, or other ongoing adjustments, in the compensation system for midwives.

The Hay Health Care Group was the successful applicant with their extensive health care knowledge, including in the community health sector.[70]

4. Working with the Hay Health Care Group

120. At the project planning stage we established a Steering Committee and met with Hay Group principle Moshe Greengarten to confirm the scope of the project, assist the Hay Group to gain an understanding of the issues that formed the basis of the 1993 funding arrangements and to discuss proposed approaches to structuring compensation and to determining the appropriateness of the benefit and operations fees.

121. We worked closely with Greengarten to assist in gathering relevant information which Hay required. This included providing him with the information provided to him – included information originally used by the Joint Funding Work Group including the Morton Report and AOM papers provided to the Joint Funding Work Group.

122. A key decision at this stage was deciding the appropriate comparator professions. The Hay Group framed this discussion for the Steering Committee in the context of establishing a compensation strategy (that is, the framework of pay

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69 Request for Proposals compensation review project (2003). AOM0005884.

70 Hay Bid for Comp Review (2003-02-12) AOM0005868.

within which staff will be paid). As stated in the report the Steering Committee concluded the following key points:

• *The comparator professions include the Family Physician employed by CHCs and the Nurse Practitioner, which is a relatively new professional nursing category and was not in existence per se in 1993. (In 1993, the Primary Care Nurse position was considered the comparator nursing position in the CHC; this position is no longer funded by the Ministry of Health). However, the following key differences between these comparator professions and Midwives should also be taken into account:*

– They do not have the requirement to work 24/7 on-call;

– They are salaried positions; and,

– Neither has fiscal responsibilities

It was also agreed that another physician model that could be considered a comparator is the fee-for-service model for family physicians who bill under OHIP.

• *The market positioning should fall "somewhere" between the pay levels of a Family Physician and a Nurse Practitioner.*[71]

123. The Hay Group also collected relevant market and other research information for assessment purposes. The Hay Group was responsible for data collection, drawing on Greengarten's extensive community health consultation experience as well as the Hay Group's resources and external surveys.

5. Hay Health Care Group Reports and Recommendations

124. This led to the Hay Group's report dated June 2003, "Association of Ontario Midwives – Compensation Review" [72] which was subsequently updated in February 2004 to include updated compensation information reflecting substantial increases for the CHC physicians.[73]

125. The June 2003 Report provided a number of recommendations for consideration in the establishment of competitive, fair and equitable compensation levels.

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71 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195.

72 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195.

73 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report AOM0001369.

126. First, it was recommended that a "Job Rate" be established. The Report states that the term “job rate” refers to the pay rate that a fully qualified incumbent would typically earn.

127. The Report provided two options for establishing a fair and equitable job rate for Midwives. (The options assume that the CHC data are “aged” to bring them to the equivalent of 2002 dollars):. a) The first option was to replicate the 1993 methodology. b) The second option was to reflect proration of hours work. This would be similar to the first option 1, except that the proposed annual job rate would be prorated to reflect the difference in hours worked which was about 35 hours per week for CHC physicians and 44 hours approximately for midwives.

128. The report also recommended factoring on-call pay into compensation comparisons. The Hay Group observed that:

The CHC Physician salary used for the basis of comparison in the above two options includes an on-call allowance of $5,000. However, this amount does not adequately reflect the onerous on-call schedule necessitated by the midwifery model of care. The on-call schedule places considerable stress on Midwives.

We also note that other health care professions receive on-call premiums and that these premiums are typically higher for on call during weekends and holidays.

We therefore propose that an on-call premium amount be factored into our recommended job rate to recognize the significant amount of on-call time necessitated by the profession, which, to the best of our knowledge, is not a requirement of any other type of health care profession.

129. The Hay Group used information we provided to calculate that a midwife's on-call requirement represents an average of approximately 4,400 on-call hours per year which translates to $1.27/hour. They found that this was "clearly insufficient to recognize the amount of on-call for the midwives particularly when a large portion of on-call takes place during nights, weekends and holidays." They noted the approximate average of regular and premium on-call for Ontario Nurses is $5.00/ hr.

130. In light of the above, the Report recommended:

that the appropriate job rate for Midwives is $2,575 per BCC, or $103,000 annually (based on an average of 40 BCCs per year). The job rate is broken down as follows:

“Base” rate $2,025/BCC or $81,000

“On-call” rate $550/BCC or $22,000

131. The report noted that if the maximum salary level had been adjusted for CPI, the 2002 maximum would be between $86,600 and $88,700.

132. The Report also noted that regardless which option was selected, the rate should keep pace with the market by means of cost of living adjustments. Based on a range of considerations the Report recommended that the benefits percentage be increased to 20% from 16%. The Hay Group noted that the 20% benefits rate is consistent with the benefits rate of the Midwives' two key market comparators: Nurse Practitioners and CHC physicians.

133. The Hay Group was not able to conduct a comprehensive analysis regarding operational fees but did recommend adjusting such fees annually by an appropriate inflationary factor.

134. Following the publication of our Report, the Hay Group developed and delivered a power point to present their findings to the AOM.[74] At that May, 2003 Annual General Meeting, AOM members voted to accept report and begin negotiations with OMP.[75] The members subsequently in a survey asked the AOM to move as quickly as possible in advocating for a compensation increase.[76] They were particularly concerned to get a process in place so that they did not have to wait another 10 years for a compensation review and equitable compensation. Midwives were also concerned that the frozen compensation was contributing to midwifery attrition. [77]

6. Advocating with the Ministry

135. On July 24, 2003, I wrote to MOHLTC Minister Tony Clement requesting a meeting to establish a new compensation package for our membership. The letter states as follows and highlighted are ongoing concerns with the MOHLTC's continuing freezing of midwifery compensation since 1994:

On behalf of the Association of Ontario Midwives, I am writing to request a meeting with you to discuss a new compensation package for our membership. I would ask that the meeting be scheduled at your earliest convenience in order that we can continue to pursue our common objectives – increasing and improving the obstetrical services available to Ontario's mothers and their newborn children – without impediment.

A major impediment is compensation. As you may be aware, midwives are paid the same amount today as they were 10 years ago when the province first

74 PowerPoint Report by Hay Health Care Group re: Compensation Review Findings and Recommendations (May 28, 2003) AOM0002200.

75 Agenda for AOM AGM June 2003 (2003-06-04) AOM0005844.

76 AOM Compensation Update (2003-07-17) AOM0002183.

77 Results of AOM Compensation Strategy Ballot (2003), AOM0002137.

recognized and began funding the profession. There are very few professions that have worked through the past decade without an increase in compensation. We believe, and I am sure you agree, that it is past time to address this important question.

In the decade during which it has been recognized by the province, midwifery has evolved into an essential component of obstetrical care, particularly in under-serviced areas of Ontario. Midwives care for women enjoying healthy, normal pregnancies and, as such, reduce demand on obstetricians and general practitioners, freeing them to care for more complicated cases. There are, as you are aware, a decreasing number of obstetricians and general practitioners willing to provide obstetrical care across Ontario.

Consequently, there are many communities in which midwives are the only obstetrical care providers that have the potential to meet the future growth in demand.

Additionally, because they attend home births, midwives also relieve pressure on hospitals and, as we saw during the recent SARS outbreak, this can be vitally important during crises, particularly those caused by nosocomial infections.

Most importantly, our clients are extremely satisfied with the care they receive from midwives and are strongly and actively supportive. For these, and other, reasons, Ontario midwives firmly believe the province should review and increase our compensation now. Given the important role that midwives play in providing care to expectant mothers and their newborns, the province must move quickly to establish competitive, fair and equitable compensation if we are to continue to attract and retain qualified, dedicated practitioners.

Pursuant to our common objective of growing the profession, the AOM hired an independent expert – the Hay Health Care Consulting Group – to review Ontario midwives' compensation. The Hay Group, in their Report, emphasized that "fair and appropriate compensation of Midwives is critical to ensure the continuation of the midwifery profession, in order to attract qualified individuals, reduce attrition and recognize the particular stresses that are attendant upon this group of professionals."

And we agree.

The Hay Report, which has been reviewed and approved by our 260 members, is enclosed for your review.

The Hay Group recommended that midwives' compensation be set at a single job rate of $2,575.00 per course of care, up to a maximum of 40 courses of care annually. In addition, the Hay Group recommended that the compensation in lieu of benefits be increased to 20% to ensure that the value of the midwives' benefits plan is comparable to similar professions' plans.

The single job rate – and alternative approaches put forward by the Hay Group – was debated at length by our membership at our June Annual General Meeting and ultimately approved as the simplest and fairest means of compensating midwives for the important work they perform.

This compensation level was calculated after comparison with other health care practitioners. The Hay Group's methodology is described in greater detail in the enclosed Compensation Review.

Midwifery is at least as cost efficient as care by a physician, a fact that we expect will be confirmed by the Program Evaluation that is currently underway at your Ministry.

Not addressing midwifery compensation now will unquestionably decrease the availability of obstetrical care in Ontario in the near future. There is already a significant attrition rate among midwives. According to the preliminary results of a survey currently in the field, this is due in large part to the lack of remunerative offsets for the time and other pressures of the profession. Of further concern is the fact that enrolment in the midwifery education program is declining and some Ontario-trained midwives are leaving for other jurisdictions or other professions. Increasing midwives' compensation levels is one way that the province can continue to support the program and promote the growth of the profession. Ontario families have benefited from your support for midwifery in the past, Minister, and we sincerely hope that you will continue to support our profession.

Accordingly, we would very much appreciate the opportunity to meet with you so that we can settle the question of compensation for midwives in as timely a fashion as possible.

We look forward to meeting with you. We will call your office on July 29 to arrange the meeting. [78]

136. On August 5, 2003 I wrote to MPP Sandra Pupatello in her role as Liberal Health spokesperson. I asked to meet with regard to the important issues of the decrease in physicians providing obstetrical care and the importance of fair compensation to prevent midwife attrition.

137. On August 27, 2003, Michelle Heitshu, AOM Director of Policy and myself met with Minister's office staff Heather Devlin and Wendy Katherine. We reiterated the concerns raised in our above-noted letter to the Minister including about midwifery attrition and that proper and fair compensation was necessary to support the growth of the profession. I asked that midwifery compensation increases be included in the upcoming budget cycle. Devlin stated that compensation issues would need to wait until the OMP Program Evaluation had

78 Letter dated July 24, 2003, from Remi Ejiwunmi, president of Association of Ontario Midwives to The Honourable Tony Clement, Minister of Health and Long-Term Care AOM0005859.

been completed; however, once it was completed, compensation would be looked at with the evaluation as the basis for reviewing the compensation issue. At that meeting the Ministry staff acknowledged that the Minister made a promise at the AOM AGM to look at the compensation issue.[79]

138. On behalf of the AOM I continued to raise the issue of compensation at meetings with the Ministry. In early September 2003 I had an email exchange with Heather Devlin where she agreed that the Ministry had made a commitment to work with the AOM on a compensation review process to be considered in the upcoming budget cycle. However, Devlin indicated that the Minister would not sign a letter of intent to that effect.[80] [81] [82]

139. I again raised the issue of a compensation review and equitable compensation at the AOM/OMP meeting on November 26, 2003 with little response from the OMP.[83] At this meeting we also raised another key issue - the unilateral demand by the MOHLTC to require midwives to conduct infant hearing tests on all clients. The AOM did not oppose this from a clinical point of view, but rather took issue with this significant task being added to the course of care without respect to compensation issues. [84]

140. On December 15, 2003 I wrote to then new Liberal Minister of Health George Smitherman to request a meeting to discuss the serious challenges facing midwives in providing obstetrical care.[85] The Liberals had been elected in the October 2003 provincial election.

141. In the above-noted letter, I:

(a) described the essential role that midwives play in maternal health care in Ontario but that "the important role being played by midwives is being threatened by a very high attrition rate in the profession and a decrease in the number of applications to education programs to become midwives."

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79 Email from M Heitsu (AOM) to various AOM midwives and Hartwell group re recent ministry meeting, and talking points for Remi used at meeting (August 27, 2003) AOM0001340 or AOM0002213.

80 Various email between R. Ejiwunmi and H. Devlin, copying W. Katherine and L. Sheinbaum from September 3 to 9, 2003 re: Compensation Review (2003-09-09) AOM0002145.

81 See Memo from AOM to membership re: Compensation Update, (September 8, 2003), AOM0002213.

82 See Memo from AOM to membership re: Compensation Update, (September 8, 2003), AOM0002213.

83 Agenda for AOM - OMP meeting with handwritten additions (2003-11-26) AOM0001347.

84 Emails between AOM and OMP re: meetings, (October 10, 2003), AOM0001332.

85 Letter from Remi Ejiwunmi, President, AOM to George Smitherman, Minister of Health and Long-Term Care (2003-12-15) MOH004083.

(b) asserted that fair and appropriate compensation would be a way to grow the profession and that midwives were being paid rate as ten years prior.

(c) acknowledged that we had been told that a review of compensation would have to come after the results of the OMP evaluation.

(d) urged Minister Smitherman honour the previous government's commitment to address compensation in the upcoming budget cycle, given that the evaluation results were released and given the urgency of the matter.

(e) requested the minister's assistance in establishing a process for moving forward.

7. MOHLTC Critiques and Questions Regarding Hay Health Care Group 2003 Report

142. The MOHLTC requested more detail about the comparator professions used in the Hay Group report. In January 2004 the Hay Group provided a document responding to the request: In February, 2004 we asked the Hay Group to respond to a number of additional questions raised by the MOHLTC concerning the June, 2003 Report. In response to those questions the Hay Group produced a document dated February, 2004, "Critique of Hay Group Report." [86] This February, 2004 document addressed the additional critiques raised by the MOHLTC. This is detailed in the Moshe Greengarten affidavit.

8. February 2004 Updated Hay Compensation Review Report

143. In 2004 we became aware of significant salary changes for CHC physicians who, as of 2004 now earned a range of $106,216 to $127,971 in fully serviced areas and a range of $124,848 to $150,419 in underserviced areas. These numbers did not include on-call payment. With their increase in compensation, physicians also experienced a reduction in their on-call rates.

144. We therefore requested that the Hay Group prepare an updated version of the 2003 report with updated salary information up to 2003 (rather than 2002 as reflected in our 2003 report).

145. The Hay Group carried out a further investigation to update the compensation information in the 2003 report. As a result, they revised our 2003 report to incorporate this updated information which also led to a revision in our compensation recommendations.

146. As a result of a substantial salary increase to CHC physicians in 2003 which was not reflected in the 2003 Report (which used data to 2002) and the passage of a

86 "Critique of Hay Group Report" prepared by Hay Group, February, 2004 AOM0002240.

further year, the new Hay Report revised its recommended Level of Compensation (changes from 2003 report noted in brackets):

We recommend that the compensation of Midwives be set at a single pay rate of $2720 per BCC (up from $2025) ($108,800 (up from 103,000) on an annual basis) as representing a level of compensation that compensates the profession of Midwives fairly. The single pay rate is broken down as follows:

"Base" rate $2,390/BCC (up from 2,025) or $95,600 (up from 81,000)

"On-call" rate 330 /BCC (down from $550) or 13,200 (down from $22,000)

We further recommend that the job rate be maintained in accordance with the market by means of a cost of living adjustment on an annual basis.[87]

147. The 2004 Report also provided updated recommendations for job rates:

Option 1 assumes that the same methodology used to establish the 1993 compensation is replicated.

The proposed job rate is $100,000 *($2,500 per completed BCC), which represents 90% of the minimum amount paid to the CHC Family Physician (in fully-serviced areas) based on a 35-hour work week, and including the on-call amount• The CHC Family Physician updated salary range data (using the more conservative type of $5,000 per year.*

Option 2: Reflect Proration of Hours Worked

This option is similar to Option 1, except that the proposed annual job rate has been prorated to reflect the difference in hours worked.

The ***proposed job rates of $125,800*** *($3,145 per BCC) represents 90% of the entry rate of the CHC Family Physician based on a 44-hour work week, including the $5,000 per year on-call allowance. This amount has been determined using the following assumption:*

The CHC Family Physician 2004 salary range minimum is $111,216, which includes the $5,000 per year on-call allowance. When the difference in hours worked per week is factored in, the entry rate becomes $139,800 and therefore, 90% represents $125,800.

With respect to on-call rates, the Report made the following change:

To calculate the value of on-call hours for the Midwife, we have assigned an hourly rate of $3.00 or $330per course of care ($3.00x 110 hours) which we

87 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report, AOM0001369.

believe appropriately recognizes the amount and timing of on-call requirements for the Midwife. However, we note that according to our market review, the proposed hourly rate ***is at the low end*** *of the regular and premium hourly on-call rates for nurses in Ontario.*

9. Principles of Funding (2004)

148. In anticipation of negotiations with the OMP on issues related to the funding agreement and compensation for midwives the AOM in early 2004 developed a revised set of guiding "Principles of Funding".[88] These were developed during my presidency and ratified by members during Elana Johnson's presidency. These principles were built on the Principles document that had been developed and ratified by the members in 1998 to assist in guiding those funding agreement negotiations.

149. The document acknowledges that there is one central negotiation process, which takes place between the Ministry and Ontario midwives, represented by the AOM. The principles emphasis the need for fair and appropriate compensation practices.[89]

10. Initial Response of MOHLTC

150. In February 2003 the Minister's office responded to our December 15, 2003 letter requesting a meeting to discuss compensation.

151. I attended a meeting between the AOM and Jason Grier , Director of Policy and Legislative Affairs on February 18, 2004. The focus of the meeting was: a) the crisis in obstetrical care, b) Midwifery's role, c) midwives leaving the profession and province, d) compensation. We obtained a commitment from the MOHLTC to work on the compensation issues and meet again in the first week of March.[90] [91]

152. We provided the MOHLTC with an updated February, 2004 version of the Hay Report which showed the increased compensation which Hay was aware of which had been paid to the CHC physicians as a result of the OMA's negotiations on their behalf. [92]

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88 AOM Principles of Funding (2004) AOM0001790.

89 Memo from AOM to All Members re: Ratification of Principles of Funding and other documents (7/9/2004) AOM0002234 at p 7.

90 Talking Points for AOM Meeting with the Office of MOH re: crisis in obstetrical care and increase in compensation and numbers of midwives.(February 18, 2004), AOM0002224.

91 Draft agenda for AOM Meeting with Office of the Minister of Health, re: crisis in obstetrical care, midwifery role, compensation., (February 18, 2004) AOM0002236.

92 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report AOM0001369.

153. We also had Hay prepare a document which answered some questions which the MOHLTC had about the June, 2003 Hay Report.[93]

154. We continued to meet with the Minister's staff. The AOM's Alison Dantas also wrote to Minister Smitherman on March 1, 2004 providing a package of information about how the AOM and Ontario's midwives could contribute to the MOHLTC's health reform priorities and objectives.[94]

155. No action was taken by the Ministry nor any response provided to address the Hay report's findings or the inequitable compensation. The ongoing lack of a fee increase was causing concerns about recruitment and retention with midwives able to leave the province for other jurisdictions.

156. However, in a speech on May 13, 2004, during the 2004 AOM annual conference, then Minister of Health and Long-Term Care George Smitherman stated that the Ministry was planning for a significant expansion of midwifery services. He described the contributions of midwives "from a value standpoint" as "extraordinary". He also stated:

I don't want to be anything but entirely direct when I suggest that the challenge of both expanding the quantity of services…and trying in one fell swoop to address compensation pressures that have been allowed to arise over a period of time …is near impossible.

157. At that Annual General Meeting Elana Johnson took over as the new AOM President.

XIII. ONTARIO MIDWIFERY PROGRAM EVALUATION (2003 - 2004)

158. In 2001 the Ontario Government adopted a zero-based budgeting principle. Ministries were mandated to engage in a process of preparing operating budgets as if they had no authorized funds and then reviewing how programs could be changed to save money and improve services. The strategy required all Ontario Ministries to evaluate all programs for relevance, efficiency, affordability and sustainability. Ministries would then report back on whether programs met the goals of: fiscal responsibility, accountability and value for money.

159. The Ministry of Health and Long Term Care engaged in an evaluation review of the Ontario Midwifery Program in the spring of 2003. The program objectives for the OMP which had existed since regulation were identified as: [95]

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93 "Critique of Hay Group Report" prepared by Hay Group, February, 2004 AOM0002240.

94 Agenda and Package for Meeting between AOM and MOH re: Support for Growth of Midwifery and attaching March 1, 2004 letter from Alison Dantas to Minister Smitherman AOM0002235.

95 Ministry of Health and Long-Term Care Program Evaluation 2002-2203 to 2005-2006: Terms of Reference (2003-03-05) AOM0014083.

(a) Consumer involvement in planning, delivery and evaluation of services;

(b) greater equity in access to midwifery services across Ontario; and

(c) an equitable funding mechanism that supports the integration of midwifery services into the funded health care system.

160. The Program Evaluation Working Group (PEWG) included MOHLTC staff, representatives of the AOM, CMO, MEP and TPAs. Executive Director Alison Dantas and I were invited to serve as "External Stakeholder" representatives for the AOM on the Midwifery Program Evaluation Working Group, as per the invitation from the OMP's Wendy Katherine by letter dated February 5, 2003 and the PEWG's terms of reference.[96] [97]The OMP's Sue Davey chaired the Working Group. An outside consultant ABS consultant was contracted by the ministry to support.

161. The AOM provided information to the review about the inequitable compensation received by midwives relative to their value and contribution to the Ministry's primary health-care objectives and the recruitment and retention issues. For example, the AOM provided templates of partnership agreements and projections for the numbers of registered midwives from 2002 out to 2020. [98]

162. We were repeatedly told by the Ministry during these discussions that compensation issues could not be dealt with before the evaluation was completed. The process of review was extensive and comprehensive including gathering data from internal and external shareholders, and conducting primary research through questionnaires.[99]

163. The results of the OMP evaluation were presented at the final Working Group meeting on September 10, 2003.[100] The evaluation concluded that " the Midwifery program has achieved remarkable progress towards meeting its business objectives in the 9 years of the program's existence."[101] It further noted

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96 Letter from OMP to AOM re. Establishment of Program Evaluation (February 5, 2003) AOM0001335 and AOM0014078.

97 Midwifery program evaluation Working Group final Terms of Reference, (March 5, 2003), AOM0001329.

98 Email from M Heitsu to W. Katherine & S. Knox re: Program Evaluation Information, (April 7, 2003), AOM0006383.

99 Agenda and minutes for 3rd stakeholder meeting re. midwifery program evaluation, (April 23, 2003), AOM0001328. Minutes Midwifery Program Evaluation Stakeholder Meeting, (September 10, 2003), AOM0014018.

100 Midwifery Program Evaluation Program Evaluation Working Group (PEWG) 4th Stakeholder Meeting (2003-09-10) MOH004326.

101 Midwifery Program Evaluation Program Evaluation Working Group (PEWG) 4th Stakeholder Meeting (2003-09-10) MOH004326 p 6.

that, “midwifery care should be promoted as it is provides cost avoidance opportunities for the health care system, and that the program is in alignment with the ministry's key strategies, vision and core businesses."[102]

164. At this same meeting, the MOHLTC presented a PowerPoint presentation “Ontario Midwifery Program Evaluation,” which summarized the results of its recent Program Evaluation. The PowerPoint stated that, consistent with the April 19, 2001 Throne Speech and June 2002 Budget Commitment, the evaluation policy of the government was to ensure “government’s priorities, commitments and key strategies are met and its core businesses are delivered within a framework of fiscal responsibility, accountability and value for money. The OMP program was therefore evaluated to examine four areas of program performance: core business relevance, effectiveness, efficiency and accountability and sustainability.”[103]

165. The Power Point stated that a key program objective is to “provide an equitable funding mechanism that supports the integration of midwifery into the funded health care system”. As well, an objective was to “increase access to obstetrical providers in Ontario and “meet the need for midwifery services in Ontario.” [104]

166. The findings included survey data that consumer satisfaction with midwifery services was approximately 98% on a variety of satisfaction measures. As well, it stated that "current costs for midwifery care in the home and hospital settings with better clinical outcomes are less expensive and comparable to hospital obstetrical services by physicians.” [105] The PowerPoint also detailed in a chart the 1999-2003 Supply and Demand for Midwifery Services showing demand increasingly was outstripping supply within 2003-2004 8,200 clients being served and 14,187 clients seeking service, i.e. 57% of clients able to be served.[106]

167. The Evaluation further concluded: “with improved ministry budget co-ordination and attention to integration of midwifery services into hospitals, the expansion of midwifery services may provide further health system cost-avoidance opportunities”.[107] “International studies of midwifery care support the premise that

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102 Midwifery Program Evaluation Program Evaluation Working Group (PEWG) 4th Stakeholder Meeting (2003-09-10) MOH004326, p 15.

103 Presentation of the MOHLTC to AOM re: Ontario Midwifery Program Evaluation (May 13 2004) AOM0001370 at Slide 2-3.

104 Presentation of the MOHLTC to AOM re: Ontario Midwifery Program Evaluation (May 13 2004) AOM0001370 at Slide 22.

105 Presentation of the MOHLTC to AOM re: Ontario Midwifery Program Evaluation (May 13 2004) AOM0001370 at Slide 10-12 and 23.

106 Presentation of the MOHLTC to AOM re: Ontario Midwifery Program Evaluation (May 13 2004) AOM0001370 at Slide 25.

107 Presentation of the MOHLTC to AOM re: Ontario Midwifery Program Evaluation (May 13 2004) AOM0001370 at Slide 10-12 and 23.

midwifery care is cost effective and often results in cost reductions, while maintaining or improving the overall quality of care given to low risk women". "In countries where midwifery is well-established it is widely accepted that midwives can provide primary care to 60-80% (low risk cases) of the general obstetrical population. Midwifery care is currently available to 6% of women in Ontario" [108]

168. The Program Evaluation did establish that midwives were achieving better health outcomes than family physicians on five different measures: the rate of C-sections, operative vaginal deliveries, episiotomies, discharge from hospital within 48 hours and breastfeeding at six weeks.[109] The Evaluation also found that "20% of all consultations taking place in 2002-2003 were not required by CMO protocols but rather by the requirements of an individual physician or hospital. Midwifery Program Expectations – Ideally midwives should determine all consults within their scope of practice."[110]

169. Despite the completion of the evaluation in September 2003 there was still no movement by the ministry to address compensation. However, it did note that in 2001, "the ministry addressed fiscal inequities for physicians receiving referrals from midwives,"[111] and that the ministry could do more with specific hospitals that restrict midwifery practice.

XIV. OTHER ISSUES: LACK OF ASSURED FUNDING FOR NEW REGISTRANTS

170. I am very familiar with the difficulties caused to midwives as a result of the lack of assured funding for new registrants.

171. New midwives graduate in May of each year and often are unable to start work until the fall as a result of the OMP budgeting delays. These delays create issues with access to care for those women who want midwifery care, and creates significant disruption and stress in midwifery practices as the practices try to book women into care without certainty about the timing of funding.

172. MPGs need to have a funding agreement in place by January of each year in order to be able to take on new registrants in time for the next fiscal year. MPGs are forced to decide whether to gamble on when and whether new registrant funding will be approved in order to enroll clients for those graduating midwives.

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108 Presentation of the MOHLTC to AOM re: Ontario Midwifery Program Evaluation (May 13 2004) AOM0001370 at Slide 24.

109 Presentation of the MOHLTC to AOM re: Ontario Midwifery Program Evaluation (May 13 2004) AOM0001370.

110 Presentation of the MOHLTC to AOM re: Ontario Midwifery Program Evaluation (May 13 2004) AOM0001370.

111 Presentation of the MOHLTC to AOM re: Ontario Midwifery Program Evaluation (May 13 2004) AOM0001370.

173. For example, this year my MPG has still not received its budget approval As a result, it's not possible for us to meet our cap for women who would deliver between April 2016 and March 2017 because all those women due before the budget approval is released are already pregnant and in care with other providers. We can't go back in time and contract midwives for them when they would have been seeking care. That's why it often looks like we're not using what we're given. By the time we are notified of our budget approvals, it's too late to provide care to the women who would have been seeking it. In my experience it is a common occurrence for Midwifery Practice Groups to be waiting on budget approvals until October or November. The problem is exacerbated because the approval timing is also unpredictable. It can come anywhere from June to November with no standard date being able to be anticipated.

174. While we have repeatedly tried to get the MOHLTC to fix this problem, it still arises causing reduced access to care and financial insecurity for midwives.

XV. INCREASE IN VALUE OF MIDWIVES' SKILL, EFFORT, RESPONSIBILITIES AND WORKING CONDITIONS FROM 2001 TO 2004

1. Introduction

175. During the period 2001 to 2004 I observed the increasing demands and complexity of midwifery clinical work in Ontario.

176. During the period 2001 to 2004, midwives continued their significant contributions to the development of midwifery services and primary health care in Ontario. As a practising midwife at that time, I have first-hand knowledge of the increasing skill, effort and responsibility required of midwives during this time. The demands and complexity of midwifery work were increasing and this included both increasing business and practice management responsibilities as well as clinical demands.

2. Clinical Changes

177. There were numerous clinical changes, which affected midwifery work during this time period. These include but are not limited to the following:

178. There was an increase in the types of genetic testing offered to clients and consequently more screening and counselling; increased non-clinical issues as well as reporting responsibilities; more data and reporting requirements and accountabilities; and increases in human resources and practice management issues as practice groups increased in size and complexity.

179. Further, in May 2000, the CMO published a document outlining changes to guidelines on consultation, discussion and transfer of care between midwives and physicians.[112]

180. As noted above, in 2003 the Ministry introduced the Infant Hearing Screening initiative without consultation with the AOM and without compensation for the additional work. The AOM received significant negative feedback from members, who asserted that it created substantial unpaid work, was a duplication of resources; involved costly equipment, training and administration and it segregated midwives from other hospital professionals.[113] It continued to be in place until this past year when it was dismantled and taken into regional Infant Hearing Screening centres for the screening to be done by the program rather than by midwives.

181. There was also the Public Health initiative, Healthy Babies Healthy Children screening tool that all midwives had to ensure occurred on every baby born, whether at home or in hospital.

182. Most recently with the implementation of the Hyperbilirubinemia QBP, all babies must be screened for jaundice between 24-72 hours of age.

183. Midwives are also now required to handle the issuance of Infant Health Cards for infants born at home.

184. In September of 2004, a regulation under the *Midwifery Act* was proposed that would amend the Pharmacy Act, to enabling midwives to prescribe more drugs. The CMO also proposed an expansion to the Laboratory testing and Diagnostic roles of midwives. New additions to proposed drug regulation amendments approved by council of the College of Midwives in Ontario June 22, 2005

185. Other CMO Guidelines during this period included the Guidelines to the Policy on Active Practice Reporting Requirements, [114] Policy on Continuing Competency in Emergency Skills[115] and Policy on Blood Borne Pathogens.[116]

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112 CMO Notes on Changes to Indications for Mandatory Discussion, Consultation and Transfer of Care (revised) (5/1/2000) AOM0001171.

113 Minutes from AOM Board Meeting (2003/01/22) AOM0002181.

114 CMO Guidelines to the Policy on Active Practice Reporting Requirements Revised April 2003 (2003-01-04) AOM0015839.

115 CMO Policy on Continuing Competency in Emergency Skills Revised November 2003 (2003-01-11) AOM0015808.

116 CMO Policy on Blood Borne Pathogens (2003-09-24) AOM0015818.

3. Practice and Administration Changes.

186. Following devolution, midwives had increased responsibilities as a result of the new independent contractor relationship.

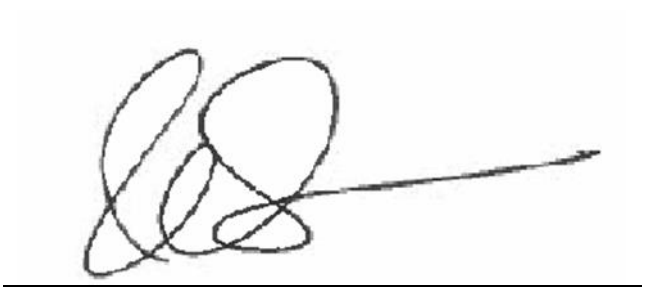
187. Midwives became responsible for preparing invoices for midwifery services, upon which they would write the courses of care, caseload variables, travel, and other details.[117]

188. During my time as president, the AOM produced a version of the Practice Management Guide providing information for midwives about how to set up an MPG. The guide included information on contractual status of midwives and how to make sure associates are not employees.[118]

189. In April 2003, the Ministry initiated a new mandatory system of data entry by midwives that had to be completed in order for midwives to be compensated. This added to the non-clinical responsibilities of midwives required by the Ministry. Midwives appear to be the only profession required to directly input all health data of their clients into the ministry database themselves in order to get paid. As well, the transition and transformation of that initial data entry program, which started as a one page document, evolved into a 6-page document and then into the current BORN online data entry form with hundreds of fields, has also been onerous.

SWORN this 27th day of July, 2016.

A Commissioner for taking Affidavits



Remi Ejiwunmi

117 Midwifery Services Invoice (1999) AOM0014270.

118 Manual by AOM re: The Business of Midwifery (2002-12-04) AOM0006468.