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 ELANA JOHNSON

I, Elana Johnson, of the City of London, in the Province of Ontario, MAKE OATH AND AFFIRM as follows:

1. I am a registered midwife in the Province of Ontario and engaged in the clinical practice of midwifery for 22 years. I was also President of the AOM twice from 1988-1989 and 2004-2008. I retired from clinical midwifery in 2007. I have also most recently been part of AOM funding negotiations with the MOHLTC from 2007 to 2009, and again from 2015 to present. I am also a complainant in this proceeding.

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

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1 Curriculum Vitae of Elana Johnson, AOM0017381.

I. BACKGROUND

1. Education and Knowledge

3. I decided to pursue a career in midwifery after the birth of my second child. At that time, doctors had recently been instructed in Ontario to stop doing home births. There were no practicing midwives at that time in my area.

4. Throughout the 1980s, I sought out midwifery education and training programs. Initially, I worked in apprenticeship arrangements, engaged in a self-directed learning program, and received evaluation from other midwives following the program the Michigan Midwives Association set out.

5. I took a Childbirth Educator Training course in 1979-1980 and earned my Childbirth Educator and Birth Assistant certification from the organization Informed HomeBirth in 1982 to enhance my midwifery apprenticeship education.

6. I successfully completed my midwifery training in 1984 with successful completion of the Michigan Midwives Association Midwifery exam in 1984.

7. I then attended a one month midwifery residence at the Maternidad La Luz in Texas in order to advance my midwifery skills, including suturing and administration of emergency injections.

8. I then completed and graduated from the Michener Institute of Health Sciences Pre Registration Programme in 1993.

2. Practicing Midwife

9. I practiced as a midwife for over 22 years. I established a solo practitioner midwifery practice in London, Ontario in 1985. I expanded my practice and took on other midwives after the first graduating class of midwives. The practice Womancare Midwives has now grown into a group practice of 13 midwives. I was the founding partner and as such was responsible initially for the financial and administrative responsibilities.

3. AOM/ CAM Roles

10. I was a leader in the AOM prior to regulation. I have twice been its President, from 1988-1989 and again from May 2004 to May 2008. I was Co- Chair of the AOM Negotiations Committee in 2007-2008.

11. Prior to regulation, I was an AOM liaison member to the Interim Regulatory Council on Midwifery during the early 1990's. I also made a presentation to the Task Force on the Implementation of Midwifery in Ontario at its London meeting in 1986 based on my practice and experience.

12. I was a member of the AOM's Insurance and Risk Management Program Steering committee from 2004 to 2012.

13. I am a past coordinator of the Canadian Confederation of Midwives, the predecessor to the Canadian Association of Midwives.

4. Regulatory Roles

14. I was a member of the Supervision Panel of the College of Midwives of Ontario's Registration Committee from approximately 1997 –2000**.**

5. Teaching and Education Work

15. I was a clinical preceptor for the Midwifery Education Programme from 1994 to 2004

16. I designed curricula and taught community education programs in Labour Support and Advocacy and Childbirth Preparation. I taught a History of Midwifery in Ontario community course at the University of Western Ontario in the 1990's.

17. I also conducted presentations on "Business Practice 101" and "Effective Practice Management" for the Association of Ontario Midwives Professional Education and on "Challenges and Changes in the Practice" at the Ontario Association of Midwives Annual Conference.

6. Interprofessional Collaboration and Hospital Integration Roles

18. I acted as Head Midwife for London Health Sciences Centre from 1996 to 2003 and also as Head Midwife at the St. Joseph's Hospital in London.

19. While head midwife, I sat on many inter-professional committees, including a committee focused on nurse—midwife professional relationship interaction.

20. I was the AOM member of the MOHLTC Family Health Team Action Group from 2006 to 2008. I took over from Vicki Van Wagner. This was a multi-disciplinary province wide advisory group to the Minister of Health as it introduced and implemented Family Health Teams.

21. I was a member of the multidisciplinary Ontario Maternity Care Expert Panel 2004 to 2006. Our task was to look at how to provide excellent care in the context of the looming obstetrical care provider crisis with the mass exodus of family physicians from obstetrical care and the aging of the obstetrician population.

22. I have also been active in addressing perinatal issues. I was a member of the St. Joseph Perinatal Mortality Review Committee from 1994 to 2004. This was a multi-disciplinary Committee including obstetricians, neonatologists, family physicians and nurses which reviewed perinatal deaths (death of mother or baby in perinatal period.) We took turns taking responsibility for review and presentation of cases. I was also a member of the Southwestern Perinatal Partnership from 2002 to 2004.

II. EARLY AOM WORK TO DEVELOP MIDWIFERY SYSTEM

1. Introduction

23. As one of the early practicing pre-regulation midwives, I was involved deeply in the campaign to gain recognition and funding. This lead to my being President of the AOM from 1988 to 1989.

2. AOM Presidency – 1988 to 1989

24. In 1988, I was elected president of the AOM for the first time.

25. At that time, the Task Force on the Implementation of Midwifery in Ontario (TFIMO) had just published its report that recommended, among other things, that Ontario enact a *Midwifery Act* in which the midwife's scope of practice, whether in hospitals, clinics or homes, be defined consistently with the following

International Definition of the Midwife:[2]

[The midwife] must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her responsibility and to care for the newborn and the mother. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients but also within the family and community. The work should involve antenatal education and

2 Report of the Task Force on the Implementation of Midwifery in Ontario (TFIMO), (1987), AOM0013549.

preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care.

III. DEVELOPING THE MIDWIFERY REGULATORY SYSTEM / INTERIM REGULATORY COUNCIL ON MIDWIFERY

1. Interim Regulatory Council of Midwives

26. A 13 member Interim Regulatory Council on Midwifery was appointed by Order in Council in June, 1989 to prepare for the future statutory College of Midwives.[3] Vicki Van Wagner, Bobbi Soderstrom, Jane Kilthei and I were all on the AOM's Midwifery Liaison Committee to the Interim Regulatory Council on Midwifery and served on the Council's committees.

27. In June, 1992, the IRCM's Models of Payment and Practice Committee issued its Report and Recommendations to the MOH Women's Health Bureau.[4]The report contained a series of recommendations and statements of principle that aimed to promote the midwifery model of care and to embody that model in regulatory form.

2. Funding and Compensation Discussions

28. During the AOM –MOH Joint Funding Work Group discussions in 1993, I was briefed that the discussions included a pay equity analysis in order to properly position the midwife in the funding health care system. This involved comparing the midwife with the CHC physician and senior primary care nurse/nurse practitioner.

29. At that time, I had communications with the London Intercommunity Health Centre in London and was aware generally of the roles of those two positions in the Centre.

30. In October, 1993, I received an AOM memorandum and voting package from the AOM [5]which was sent to us in order to assist AOM members in voting on the Ontario Midwifery Program Framework.[6] The memorandum confirmed that there had been a "pay equity exercise" conducted by the Joint Funding Work Group with the assistance of Robert Morton.

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3 MOHLTC News Release "Minister Announces the Appointment of an Interim Regulatory Council on Midwifery Appointment of Interim Regulatory Council on Midwifery, (June 30, 1989), AOM0002333.

4 Report and Recommendations to the IRCM By The Models of Practice and Payment Committee (MOPP) (June 19, 1992) AOM0006518.

5 Voting Package for AOM Members re Ontario Midwifery Program Framework, with attachments (October 23, 1993) AOM0001275.

6 Ontario Midwifery Funding Framework (developed by the Midwifery Funding Work Group) (September, 1993) AOM0000579.

IV. EXPERIENCES OF STEREOTYPING, PREJUDICES AND HOSTILITY

1. Introduction

31. I experienced considerable stereotyping, prejudices and disadvantages as a midwife both pre- and post- regulation. Vicki Van Wagner's 1991 Thesis, With Woman: Community Midwifery in Ontario describes this pre-regulation experience well. [7]

32. This often took the form of hostility from physicians and from some nurses as well who were used to the physician/nurse model of maternity and newborn care. Pre-regulation, organized medicine was opposed to an autonomous midwifery profession. [8] Although midwifery has gained much more widespread acceptance and recognition, I experienced prejudice, particularly pre-regulation and in the early years of practice. This included stereotypes that I and other midwives were undereducated, lacking in modern medical knowledge, and dangerous to the health of women and babies. I was often treated as incompetent by physicians.

2. Post Regulation Examples

33. In one particular case which occurred in about 1995, a client who had chosen a home birth needed a transfer into hospital and I needed to fully inform my client of standards of care given her birthing situation. The client was reluctant but eventually decided to transfer in. The OB resident did an assessment and I moved into an advocate role for client. The nursing staff were good that night, however, the male obstetrician on call refused to consult about the client. The client needed a team of care and the male obstetrician refused to be part of it as the client had chosen a midwife. Through advocacy and my other connections, I managed to resolve the situation by getting the resident to reluctantly agree to consult with me. However, I will go to my grave with that moment, not just because of the feeling of impotence but also because my client was not being given care because she had chosen a midwife. After that birth was completed, the resident said "nothing personal Elana but we believe that home birth is child abuse".

34. I had brought to the hospital a client who had previously had a C-section. I was working with a friendly female family physician who met us at the hospital. This client had been previously told by a male obstetrician that she could not have a vaginal birth as she had previously had a C section. So she sought out midwifery care. The client had the baby very quickly in the birth room. As I was going out to get warm towels for baby / mother, the same male obstetrician who was very large, physically pinned me against the wall with all these male residents

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7 Vicki Van Wagner's 1991 Thesis, *With Women: Community Midwifery in Ontario,* (September 4, 2015), AOM0017358.

8 OMA Discussion Paper on Directions in Health Care - Issues in the Implementation of Midwifery, (January 1, 1988), AOM0008628.

standing behind him. He said, 'I want to know what your role is in obstetrics.' I was incredibly upset and with my voice shaking, countered with 'do you want to meet with me to discuss this? Your office or mine?' I diffused the situation with this doctor, but it was very upsetting.

35. A female physician asked me to be her midwife at a home birth but I had to be sworn to secrecy so she would avoid flak from her physician colleagues.

36. Part of the judgment from doctors, is they feel that to have a midwife is to "betray the profession" and others just think it is very dangerous, despite all the evidence to the contrary. Some doctors view of midwives is 'All we ever do is clean up your mess!'

37. In early post regulation days, nurses also made it difficult for me and other midwives to practice in hospitals. For example, when I would arrive at the hospital with a client, some nurses would not to speak to me or help with the registration of the client. It took quite a while for all the nurses to accept the new role of midwives.

38. I have a file box full of letters from women clients expressing their gratitude to me and my colleagues. One is from a nurse who had real doubts midwives would have an adequate knowledge base. She chose midwifery care pre-regulation for her pregnancy and birth because her spouse would not be present at her birth. As a result, she went through a personal transformation; she doesn't think that she would have had the same good outcome without midwifery care.

39. I believe that every single one of these instances is illustrative of the unfair and unequal culture and conditions in which I and other midwives have had to work over the years. The onus seems to be on midwives to explain and justify our work and roles. Physicians did not seem to be required in the same way to account for the effectiveness of their practice or education. It feels like a part of our job is often to take the high road.

40. Society and government decided to fund midwifery and have it be part of the health care system in Ontario but have never acknowledged how hard it has been to bring forward a new, female dominated profession into a male dominated, patriarchal system. Midwives continued to have to fight for recognition.

V. HOSPITAL INTEGRATION BARRIERS

41. In addition to the above prejudices and hostility, I have observed and experienced barriers with respect to hospital integration.

42. In particular, I faced many difficulties practicing midwifery in a hierarchical health care system particularly in the hospital setting where physicians exercise such dominating control and influence and often have negative views about midwifery and its value.

43. Practicing midwifery in Ontario requires hospital privileges and hospitals that will permit a full scope of midwifery practice. It can be very difficult to get hospital privileges. I was able to obtain privileges at London Health Sciences Centre and St. Joseph's Health Centre. It took a lot of hard work to get those privileges, meeting with obstetricians, family physicians and administrators and finding allies who would support your privileges request.[9]

44. More than 10 years after regulation, it was still difficult for all midwives to get hospital privileges and to be able to work to their full scope of practice in the hospital they get privileges in. Hospitals also capped the number of midwives who can practice in the hospital.

45. In 2003, the AOM retained ABS System Consultants Ltd to do a survey of AOM members on the issue. Their report "A Report of the Results of the Midwifery Practice Group Hospital Integration Survey, 2003' is dated May, 2004.[10] This report was provided to the Ministry. The Ministry co-operated in providing data for the survey. The report identified a number of serious integration concerns, including: uncertainty as to where midwifery reports in the hospital structures, a wide range of recognition and responsibility for midwifery heads, quotas restricting midwife led births and difficulties obtaining timely physician consultation.

46. In September of 2004, the AOM sent a letter to its membership announcing that the Ministry was sending a letter to all hospitals that month informing them of the need to sign accountability agreements, which would establish the expectations that the Ministry has for the services that hospitals deliver, including the implementation of by-laws that "enable midwives to practice according to their full scope"[11]

47. The 2007 OMP Hospital Integration Survey[12] found that 90% of Midwifery Practice groups reported that they were currently experiencing hospital barriers to the growth of their practice.

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9 See Womancare Associates, (July 27, 1994), AOM0012781 re: work spent on hospital integration work; Application for Caseload variables by Womancare Midwives, (July 27, 1994), AOM0012778; Summary of caseload variables for Womancare Associates for LMCO, (July 27,1994), AOM0012779; Report of Caseload Variables from Womancare Associates, (July 27, 1994), AOM0012780.

10 Report by ABS System Consultants for AOM re: Hospital Integration Survey, (May, 2004), AOM0005944.

11 AOM Hospital Relations Update: New Ministry Support for Midwives' Hospital Privileges, (September 9, 2004), MOH000130.

12 Results from OMP Survey re: Hospital Integration, (April, 2007), AOM0005937.

VI. DEVOLUTION AND NEW CONTRACT 1999 - 2000

48. My practice devolved to London Health Sciences Centre St. in London as the Transfer Payment Agency (TPA). The new devolved structure and funding structure led again to more administrative responsibilities for my practice group.

VII. IMPACT OF ONGOING INEQUITABLE COMPENSATION

1. Midwifery Pay Frozen While Others Received Increases

49. We emerged from devolution with a new TPA and a new contract based on course of care fees and an "independent" contactor relationship. However, our compensation and funding for expenses remained frozen after 6 years of being part of the funded health care system. As well, my practice as well as the others were dealing with financial difficulties arising from the transition to the new independent contractor model contract and the change to being paid after care is completed. [13]

50. I was aware that AOM President Bridget Lynch had asked in November, 2000 that the Ministry make adjustments to our compensation, given the lack of any increases since 1994 while other health care providers received increases.[14]

51. In June, 2001 at a Symposium on Midwifery, I asked MOH Minister Tony Clement after he had spoken a question asking when the Ministry would address the issue of midwifery compensation. I did not get any commitment from him to address the issue.

52. I was aware that the OMA had got increased compensation for physicians while we were still frozen.

2. Impact of Ongoing Inequitable Pay for Our Work

53. When I took over the AOM presidency in 2004, midwives would come to me telling me they were going to have to leave midwifery because they could not afford to continue. Some were single mothers, some also had older parents who needed care and they had no economic ability to care for their parents or pay for child care. Childcare is particularly expensive for midwives because their work schedule is so erratic. These young women had gone through midwifery school with the government and society telling them that they were needed in the health care system, and yet they couldn't even afford child care. Midwives were worried about what their economic future would be as a midwife. They were worried

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13 Letter from E. Johnson to W. Katherine (AOM) re: Contract Issues and transition to new funding model, (February 9, 2000), AOM0003162 at p 1. Also see: Letter from Womancare Midwives to S. Davey re: Transition to New Invoicing System, (March 27, 2000), AOM0012926.

14 Letter to Sue Davey from AOM Bridget Lynch re Cost of Living Adjustment and Inflation, (November 1, 2000), AOM0002026.

about student loans, mortgages, cost of living and elder care. Student loans were a real problem for midwives as the intensity of the MEP program means that their ability to earn outside income is restricted because of their clinical responsibilities.

1. The lack of equitable pay was very hard for me on my self-esteem. When we integrated into midwifery in 1994, we went into the funded system with a good feeling that our negotiations with the Ministry and the comparison process with the CHC physician had led to a good start for our positioning in the system. It was a good feeling at that time, that there was such an effort by the Ministry at the time to value our contribution to the system.

2. After 10 years of frozen pay and neglect, the internalized message for me was that the MOH did not value our work, despite the statements by the MOH that they did value it. The proof of value for me lay in what the Ministry was actually prepared to do on compensation. While the Ministry said it was valuing midwives because it was funding new registrants and paying for the increased professional liability insurance, this is not the same as paying midwives for their services in a properly proportionate way as they had done at the time of initial regulation. Our situation was being eroded and I felt this was an erosion of the way I was valued in the system. I found it humiliating.

3. Pre-regulation, I had been a single mother and my income was close to the poverty line. In 1994, I was the major income earner in my family, although now with a partner. By 2004, my husband's good income subsidized my income. I felt that I was not making the contribution to my family's income that I had made in the past and this made me feel very inadequate. I also felt it was very unfair, given my many contributions to the health care system as set out in Part 1 above.

4. The problems I and other midwives faced as a result of low compensation were exacerbated by the extensive on-call requirements that required midwives to incur substantial atypical expenses such as child care costs in the evening, nights and weekends, and on very short notice. As well, some midwifery families chose to solve the significant logistical dilemmas of on-call child care by having a parent at home, which then reduced the families' financial resources and ability to fund retirement and other family requirements. I had parents who lived an hour and a half away in Guelph who required care and I found it difficult to do that, given my on call requirements. I also did not have the income to hire others to assist me in that care.

VIII. BECOMING AOM PRESIDENT TO ADDRESS EQUITY ISSUES: 2004

5. When I ran to become President of the AOM in 2004, my primary motivation for doing so was to address the need for equitable compensation and funding for midwives. At this point, midwives had gone 10 whole years without any compensation and funding increases and no further evaluation of our work and

pay had been conducted since the Joint Funding Working Group and the Morton Report. We had not even received a cost of living increase.

6. The MOHLTC, because of its failure to systematically address the equity of the compensation and funding of midwives over the period since 1994 had left midwives in a very difficult position. It forced midwives to try to redress a decade of frozen compensation all at once which then left us open to Ministry arguments that we were asking for too much which could not be "afforded".

7. The first two years of my presidency—2004 to 2005—were consumed by negotiations with the MOHLTC, primarily over compensation.

IX. THE OMA AND CHC PHYSICIAN PREFERENTIAL TREATMENT

8. As I started to address compensation issues, I was briefed on the MOHLTC giving priority to increases in physician compensation and particularly to our comparator, the CHC physician.

9. In 2003, while the AOM was being told by the Ministry they did not have sufficient funds to provide us with a compensation adjustment to put us in an equitable position, the MOHLTC was meeting regularly with the OMA as a result of their commitment made in the OMA agreement 2000-2004[15] to reopen the agreement in 2003. The 2003 re-opener discussions and the 2004-2008 OMA agreements in a further large increase for physicians.

10. Throughout this time, the midwives were not afforded a regular negotiation process for midwives while physicians and others were afforded such a process.

11. As well, during this time, the MOHLTC gave an increase to CHC physicians in 2003 following the 1999 CHC Hay Report which had been done and paid for by the MOHLTC. As the CHC physicians were dissatisfied with this increase, they contacted the OMA for bargaining assistance which resulted in them receiving large compensation increases in order to align them with other primary care physicians, e.g. those in Family Health Teams. .

12. This increase in compensation included moving to a salary plus incentives model. As well, physicians with more than 5 years of experience also received an additional $5000 Service Recognition Payment. Those with more than 30 years of experience received an additional $10,000 payment. As well, as a result of the OMA agreement, the funding for CHC physician’s compensation could not

15 Agreement OMA-MOH 2000-2004, (April 1, 2000), AOM0000634, at article 3.1 states " The parties agree that they will meet in March, 2003 to negotiate whether the 2% revision effective April 1, 2003 shall be increased and for this purpose may take into consideration the prevailing economic conditions".

be used for other purposes by the CHC. The OMA negotiations and deal commanded considerable media attention. [16] [17] [18]

X. 2004 AOM –MOHLTC COMPENSATION COMMUNICATIONS

1. The Hay Group Reports (2003 and 2004)

13. When I became president of the AOM in May, 2004, the Hay Group Health Care reports commissioned and paid for by the AOM in 2003 and updated in 2004 had already been developed and released. The Hay Group prepared their first "Compensation Review" report dated June, 2003[19] which I received in August, 2003 along with other AOM members.[20] The report was to be used to support our negotiations with the OMP to obtain equitable compensation., and then updated it in January, 2004 to reflect updated salary data, including the significant compensation increase received from the MOHLTC by the CHC Physician.[21]

14. In early 2004, the AOM, led by Remi Ejiwunmi, our president at that time, continued to raise the issue of compensation in meetings with the Ontario Midwifery Program (OMP), with evidence provided by the updated Hay Report. and also from the OMP Program Evaluation, whose findings had been shared with the AOM In September, 2003. [22] However, no action was taken by the OMP before I took over as President to address the report findings or the increasingly inequitable compensation.

2. The 2004 AOM AGM and Ministerial Statements

15. On May 13, 2004, during the 2004 AOM Annual General Meeting and Conference, I was elected as the new President of the AOM.

16. We had invited MOHLTC Minister George Smitherman to be the keynote speaker at the conference, hoping that given his recent statements about the importance of midwifery to healthcare in Ontario, and given the ongoing negotiations between the AOM and the MOHLTC, that he would address compensation in his remarks to the conference attendees.

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16 McGuinty facing tough decisions, Toronto Star Article, re: Liberal government upcoming challenges, (September 8, 2004), AOM0001865.

17 Article from Toronto Star re: OMA Deal, (October 6, 2004), AOM0002418.

18 MOH News Release - McGuinty Govt Continues to Move Forward with Plan to Improve Health Care, (November 26, 2004), AOM0002420.

19 Hay Health Care Group June 2003 Compensation Review Report, (June, 2003), AOM0002195.

20 Email from M. Heitshu to MPGs re Hay Report, (August 19, 2003), AOM0005835.

21 2004 Compensation Review by Hay Health Care Group – Duplicate, (February, 2004), AOM0001369.

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

17. In preparation for the meeting, midwives Remi Ejiwunmi, Carol Cameron, Kathi Wilson and I each prepared statements to respond to Minister Smitherman's remarks, depending on whether he did not at all mention compensation, provided an unsatisfactory announcement regarding compensation, or provided an acceptable announcement.[23]

18. In his speech, Smitherman said we have an expectation of a pretty significant expansion of services." "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… is nearly impossible".[24] He assumed that it was very difficult to grow the profession and also address the issue of equitable compensation. However, I observed that the Ministry was increasing the compensation of physicians at the same time as growing their profession and services.

19. After he spoke, I approached Smitherman directly at this meeting regarding the AOM's request for equitable compensation. While walking him to the door, I pressed upon him that it was critical to begin to deal with compensation and asked him if they could meet to discuss compensation issues. He stated that I should contact his staff to get compensation talks started .

20. At this same meeting, the MOHLTC presented a PowerPoint presentation "Ontario Midwifery Program Evaluation," which summarized the results of its recent Program Evaluation. The results were very positive.[25] The PowerPoint 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."[26] The findings included that:

    (a) survey data that consumer satisfaction with midwifery services was approximately 98% on a variety of satisfaction measures.

    and

    (b) that midwives were achieving better health outcomes than family physicians on five different measures: the rate of C-sections, operative

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23 AOM Internal Document, with talking points for E. Johnson, R. Ejiwunmi, C. Cameron, and K. Wilson prepping for Minister's Speech re: compensation decision, (May 14, 2004), AOM0002290.

24 Briefing note by M Heitshu for Board meeting re potential linked issues in compensation discussions, (May 27,2004), AOM0001372.

25 MOHLTC Presentation at the AOM Conference of Ontario Midwifery Program Evaluation, (May 13, 2004), AOM0000602 at Slide 2-3.

26 MOHLTC Presentation at the AOM Conference of Ontario Midwifery Program Evaluation, (May 13, 2004), AOM0000602 at Slide 22.

vaginal deliveries, episiotomies, discharge from hospital within 48 hours and breastfeeding at six weeks.[27]

21. While we were pleased that the program evaluation validated that our midwifery contributions were so excelled, the Evaluation did not address the issue of the adequacy or equity of the midwives' compensation.

22. Given how much we were contributing to the MOH's health care objectives, and our excellent client outcomes, it was very frustrating to continue to have our compensation frozen, despite our best efforts to get our compensation addressed.

XI. 2004 AOM-MOHLTC COMPENSATION NEGOTIATIONS

1. Seeking Equity from the MOHLTC

23. Following the Conference, we prepared in the AOM for following up with the MOHLTC about compensation.[28] While the Minister had acknowledged that compensation was an issue, Smitherman clearly communicated that he was focussed still on growing the profession. The Ministry already had the Hay Report but had done nothing yet to address issues in it.

24. On May 28, 2004 the AOM met with MOHLTC staff, Senior Manager, Community Health Branch, Sue Davey and OMP Co-ordinator Wendy Katherine from the OMP to commence discussions following the AOM conference.[29] The purpose of this meeting was to discuss the various issues affecting midwifery in Ontario, including compensation, changes to the funding agreement, insurance and regulatory issues, and to come to an agreement about how negotiations were going to proceed.

25. By letter dated May 28, 2004, I wrote to Minister Smitherman as a follow up to his remarks at the AOM AGM. In this letter, I stated that I appreciated his acknowledgement of the compensation issue; and I acknowledged Smitherman's concerns regarding the current fiscal environment but emphasized that this had to be considered while also ensuring adequate compensation of midwives to sustain the profession of midwifery. I also emphasized the willingness of the AOM to work with the Minister to find solutions to this issue and the issue of the growing maternity care provider crisis.[30]

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

28 Briefing note by M Heitshu for Board meeting re potential linked issues in compensation discussions, (May 27,2004), AOM0001372.

29 AOM-OMP Meeting Agenda, (May 28 2004), AOM0001378.

30 Letter from Elana Johnson to Minister George Smitherman, (May 28, 2004), MOH004050.

26. I also wrote a letter to CHPB's Sue Davey on May 28, 2004, thanking her for the meeting that day, and confirming that the parties would be discussing compensation in the upcoming negotiations. In the letter I reiterated the AOM's understanding that the goal of upcoming negotiations was to negotiate a new compensation package and changes to the funding agreement in time for the budget submission process for the 2005/2006 fiscal year, which begins in October of 2004. The letter also confirmed the OMP's earlier commitment (which had not been acted on) to provide feedback on the Hay Report, which the AOM had provided earlier in 2004.[31]

27. On June 22, 2004, I and other AOM representatives met with representatives from the OMP to discuss funding agreement issues and to set dates for the negotiations. Among the "principles… discussed as guides for [the AOM/OMP] discussions" was:

> *Equity in compensation—keep in mind the notion that midwives have to be paid on parity in order to work side by side with other primary health care providers who are offering obstetrical care. Also equity has to be kept in mind in the out years so that we build in mechanisms for constant evaluation of compensation in the future.* [32]

28. At this meeting, the AOM once again requested that the Ministry provide a response to the Hay report. The Ministry promised to provide feedback at the next meeting scheduled for July 6, 2004[33].

29. On June 30, 2004 the AOM drafted a document for the OMP setting out the AOM Principles and Goals for a New Funding Agreement.[34] These principles included aligning the compensation with other professionals and a single wage grid. As well it stated:

Principle: Fairness/Equity

- *On call compensation (Schedule C)*
- *Inflation Adjustment for expenses (Schedule)*
- *Establish depreciation formula for office equipment (Schedule)*

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31 Letter from Elana Johnson, to Sue Davey, Senior Manager, Community Health, (May 28, 2004), AOM0000677.

32 Meeting Notes of the OMP and AOM on Funding Agreement Issues, Summary Notes, from June 22, 2004 meeting AOM0001799.

33 AOM-OMP Funding Agreement Discussion Notes, from Oct. 6 2004 meeting -page 3, re: OMP forwarding Hay Group report feedback, upcoming meetings, (October 6, 2004), AOM0001817.

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

- *Update travel and other expenses (Schedule)*
- *Review BCC including incomplete courses of care, partial payments, definition (Article 1)*
- *Review caseload variables and determine needed changes*

2. July 6, 2004 Meeting with OMP

30. On July 6, 2004, I met with the Ministry's Sue Davey and Wendy Katherine along with AOM Executive Director, Allison Dantas.[35] In that meeting it appeared to me that Davey seemed to sincerely want increased compensation for midwives but no proposal was made. Davey and Katherine agreed that a compensation increase was needed, and should be analysed "in accordance with rates from other providers". The AOM was tasked to "provide more details on similarities/differences in scope, clinical responsibility and work demands between nurse practitioners, physicians and midwives." The Ministry staff also agreed at that time that regular reviews were necessary and that COLA increases in out-years should be in line with Ministry policy. [36]

31. The OMP Wendy Katherine's response to the AOM's request for regular review was that they could not put such a commitment into the Funding Agreement (because the funding agreement is between the TPAs and the PGs)", but there could be an agreement to a review between the AOM and OMP outside of this agreement. The AOM requested that such an agreement be in written form, as the same players will not always be at the table.[37]

32. At the meeting on July 6, 2004, the OMP requested that the AOM provide them with a breakdown of the differences between the professional lives of nurse practitioners, physicians and midwives.[38] The AOM then promptly created and disclosed to the OMP a document entitled *Comparator Professions: Midwives and Nurse Practitioners* which showed the differences between the two professions.[39]

33. At this meeting on July 6, 2004, in the wake of the Hay Reports, there was considerable discussion about what midwives were earning in relation to CHC

35 Minutes of "Discussion of Funding Agreement" between AOM and MOHLTC with handwritten notes (unidentified author), (July 6, 2004), AOM0010443.

36 Minutes of "Discussion of Funding Agreement" between AOM and MOHLTC with handwritten notes (unidentified author), (July 6, 2004), AOM0010443.

37 Minutes of "Discussion of Funding Agreement" between AOM and MOHLTC with handwritten notes (unidentified author), (July 6, 2004), AOM0010443.

38 July 8, 2004 Highlights of meeting.pdf, (July 8, 2004), AOM0001792.

39 AOM Document re: Comparing Midwives and Nurse Practitioners (2004) AOM0002611.

physicians and Nurse Practitioners. The OMP raised various issues with respect to the Hay Compensation review of February, 2004.

34. The AOM arranged for the Hay Group to provide a response to those issues. This included questions with respect to why the comparison focused on the CHC Physician rather than the Nurse Practitioner.

35. We subsequently requested that the Hay Group, led by Moshe Greengarten, prepare a July, 2004 document "Elaboration on Information Provided in the Compensation Review prepared on behalf of the AOM, February, 2004"[40] which responded to the Ministry's questions:

(a) The Ministry had asked for more information about the choice of the comparator professions including a table comparing key attributes, (similarities and differences) of midwives, nurse practitioners and CHC physicians that form the basis for determining appropriate compensation including controlled acts, scope, responsibilities, risk and any other relevant criteria.

(b) The Hay response noted that Hay had reviewed the role descriptions for the position but had not conducted a comprehensive analysis and comparison and could do so if requested.

(c) Hay stated that they concluded the market positioning for the midwife should fall somewhere between the Nurse Practitioner and the CHC Physician and gave supporting reasons for that in terms of the scope of practice of the professions.

(d) Hay also noted that the other two positions did not have the requirement to work 24/7 on call, were salaried positions and did not have fiscal or management responsibilities.

(e) With respect to the choice of the Nurse Practitioner position rather than the Primary Care Nurse, Hay noted that there were two positions in the CHC at the time of the 1993 review and the review used the senior one. It found that the senior one was eliminated and replaced by the Nurse Practitioner. It also found that the education of the Nurse Practitioner was closer to the midwife than the baccalaureate nurse.

(f) Hay also responded to the question about the choice of the comparison to the CHC physician rather than the Nurse Practitioner. The Hay document stated:

> *"In our study we found that the methodology utilized in the 1993 review was credible. In this methodology, the maximum pay level of the midwife was set at 90 per cent of the minimum amount paid to the CHC family*

40 Elaboration on Information Provided in the Compensation Review prepared on behalf of the Association of Ontario Midwives, February 2004, (July 2004), AOM0005816.

physician. The Primary Care Nurse position was used only as a reference point. This methodology was duplicated in our report, so in essence, it is irrelevant whether the nurse practitioner was used as a base line comparator. Nonetheless, we continue to believe that the nurse practitioner is a useful comparator, but not as an equivalent."

(g) The Hay response then sets out its analysis of the Compensation Structure Options for Midwives - "The Hay Group recommends $2390 base rate plus $330 on call per course of care for a total of $2720 per course of care.

36. At that time, the AOM also commissioned the Hay Group to draft a document explaining in more detail the rationale for a single rate of pay for midwives as independent practitioners, as opposed to a pay range, tiered depending on seniority.[41] These were provided to the OMP.

3. The Addition of 55 New Midwifery Positions in Ontario

37. Concurrent with negotiations around compensation, the Ministry was also in the process of expanding the OMP budget to fund new midwifery positions. This was a constant dynamic in OMP funding. Because the OMP required ever increasing numbers of midwives to service the increasing high demand by Ontario women for midwives, there was a constant need to expand the OMP budget which required an extensive approvals process. This remains today.

38. On July 6, 2004, Minister Smitherman wrote to me announcing a $7-million increase to the Ontario Midwifery Program to fund 55 new midwife positions.[42] The new midwifery positions were publicly announced in August of 2004.[43] In his public announcement, the Minister stated: "what better way to invest our precious health care dollars than in support of midwives who help to bring us such wonders." The issue of midwifery compensation per course of care was ignored.

39. The OMP annually required increased budgets to account for the ever increasing supply of new midwives from the MEP to address the ever expanding demand for midwives by Ontario women an d their families. This budgetary "pressure" meant that the government was constantly freezing the compensation and funding of existing midwives and putting money instead to this "pressure". The OMP benefited from the highly effective outcomes of midwives contributing to the avoiding of an obstetrical care provider shortage. By denying us equity in compensation the OMP was able to focus on expanding this "affordable" solution.

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41 Single Pay Rate for Independent Practitioners, Briefing Note by Hay Group, (July 1, 2004), AOM0002448.

42 Letter from Smitherman to AOM E Johnson announcing funding for fiscal year for all midwives in province, (July 6, 2004), AOM0001374.

43 MOHLTC News Release re new Midwives, (August 13, 2004), AOM0001927.

4. July 15, 2004 – August, 2004 Negotiations

40. Over the summer, we continued to negotiate with the OMP.[44] On July 15, 2004, the AOM drafted a Priority List of Funding Agreement Issues, which was sent to the MOHLTC, which lists the AOM demands for equitable compensation, particularly in light of practice changes.[45] [46]

41. On August 13, 2014, Minister Smitherman held a news conference and publicly announced the increased funding for midwifery positions. Minister said his goal was to "build a health care system centered on the patient and devoted to quality." He then went on to say "Midwives are an invaluable part of our government's plan. Midwifery is a living example of the health care principles we are aspiring to. They can help show us the way forward."[47]

42. I made comments at the above-noted public announcement, thanking the Minister for the expansion of funding and providing some context by explaining the maternity care provider crisis[48] Reporters at the Minister's announcement asked me questions about our efforts to get equitable compensation. While the Minister continued to talk about how valuable midwives were, we had still not seen any commitment to redressing our pay inequities.

43. We issued a statement after this announcement about the growing inequities facing midwifery including the high rate of attrition, the labour shortage of midwives and the hospital restrictions on midwives. This included the following statement:

> "Attrition is a growing problem. Midwifery is a demanding profession, with many of the same pressures such as time on-call that are driving doctors out of practicing obstetrics. On top of this, midwives have not seen an increase in compensation since 1993, putting midwives in a position that their compensation is no longer in alignment with all other health professionals with whom they must collaborate. Midwives have clearly indicated that addressing compensation is their top priority for sustaining the profession. If current trends continue, as many as 50 midwives may leave the profession in the next three years. The support of hospitals in extending privileges to Ontario's midwives is essential. Some hospitals have not yet understood the central role that midwives are taking in providing maternity care, and are slow to extend the privileges that midwives

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44 Payment Issues Draft # 1, (July 12, 2004), AOM0011011, Also see Compensation / Funding Agreement - Meetings, 2004 to Date, (October 1, 2005), AOM0002709.

45 AOM Priority List of Funding Agreement Issues, (July 15, 2004), AOM0010445.

46 Draft Discussion Tool re: Accountability, (August 17, 2004), AOM0002457.

47 Current Issues in Midwifery, AOM Information Sheet re: increased compensation and program funding, (August 13, 2004), AOM0002595.

48 Speaking Notes for E. Johnson re: Midwifery Funding Announcement, (August 13, 2004), AOM0002428.

need to care for their clients. The AOM believes that hospitals have an obligation to assist with the integration of health professionals recruited by communities themselves to provide services with Ministry of Health and Long-Term Care funding."[49]

44. As a result of lagging negotiations, in a meeting on August 17, 2004, the AOM requested that the OMP provide the legal opinion they were relying on regarding the best practice for compensation of independent contractors, and advised the OMP that we would be employing a consultant to assist in negotiations into the fall.[50]

45. The AOM prepared a number of documents to provide evidence to support our proposals and to assist in negotiations. These included a detailed list and breakdown of various compensation options,[51] a paper on the unique needs of small practices with respect to the funding agreement,[52] a memorandum and voting package that we sent to all members regarding the ratification of our principles of funding.[53] We also drafted a backgrounder on the changes in workload of midwives in Ontario,[54] which laid the foundation for the Workload Analysis Study in 2007.

46. The OMP representatives Sue Davey and Wendy Katherine repeatedly responded to our demands for equitable compensation by saying we can't be seen to be providing a compensation increase greater than the 2% which they stated was Ministry policy due to restraints. However they were not holding to this constraint with the OMA and other groups. There were some discussions about ways to put money in the pockets of midwives without it being seen as "increased compensation". This included increasing the on call fee and the operational expense fee as well as collapsing the grid from start-to-11 steps to start-to-5 steps.

5. Regional Meetings – Member Anger and Frustration

47. During the fall of 2004, the AOM held a number of regional meetings with the membership to consult them on their priorities and goals in the compensation negotiations, given the difficult negotiations to date with the MOHLTC.

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49 Current Issues in Midwifery, AOM Information Sheet re: increased compensation and program funding, (August 13, 2004), AOM0002595.

50 MOU between AOM and MOH re: Midwife Compensation Scale and Negotiations, (August 17, 2004), AOM0006515.

51 Compensation Options, August 2004, with handwritten notes, (August, 2004), AOM0002454

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

53 Memo from AOM to All Members re: Ratification of Principles of Funding and other documents, (July 9, 2004), AOM0002234.

54 Backgrounder by AOM re: Change in Workload for Midwives, (August 16, 2004), AOM0006471.

48. While midwives were not prepared to stop providing care to women, they were prepared to consider not carrying out preceptor responsibilities to students and were engaging in a public campaign about the issues.

49. The period of negotiation over 2004 and 2005 was also very difficult for me personally. As a result of the constant intense negotiations with no breaks, I could not properly emotionally support my own young adult child who had acute mental health needs at that time. Midwives continued to complain to me about their financial difficulties. It was a very hard time.

6. Negotiations in the Fall of 2004

50. In the fall of 2004, we had still not heard back from the Ministry regarding our compensation proposal. The AOM hired a government relations consultant, Leonard Domino & Associates (LDA) to assist with ensuring the government understood the midwives' concerns about equitable compensation. Leonard Domino, representing the AOM, had further discussions with Ministry staff about the need to address the compensation issue throughout the fall.

On September 20, 2004, Leonard Domino, Allison Dantas and I met with MOHLTC Assistant Deputy Minister, George Zegarac for lunch. [55]he AOM again requested that the Ministry take prompt action to redress the inequitable compensation.

At this meeting, Zegarac said that:

(a) "there is no money" and that "the government will be consistent with what everyone else gets."

(b) the OMA agreement will definitely "set the tone" [for the midwives' negotiation]; "Make the case that you have more responsibility, and risk, and are not compensated." "What is the risk of not increasing salary?".

(c) "Centre your argument around what this increase will mean for patients, not the government or midwives."

(d) "Help us understand what we get for the new money. Will there be a difference in care and how is it better?"

(e) "You must pitch recruitment and retention."

(f) "Do you have ideas on how established money can be used more efficiently?"

55 Notes by Leonard Domino from meeting with E Johnson and A Dantas and Assistant Deputy Minister Zegarac, (September 20, 2004), AOM0001379.

(g) “There may be non-monetary things that could help support midwives. If I can't get money, what other interests are important?”

(h) “It is important that you engage Sue Davey and her staff. Step up the meetings, five weeks is a reasonable time frame for an agreement.”

(i) “Remember once we have an agreement it still must be sold to the Centre (the Premiers Office), the Cabinet Committee on Health and Social Services and the Management Board.”

(j) The Minister is tired of ultimatums. If you make an ultimatum it will put an end to the discussion.

(k) The catch up argument irritates the Minister. “2% catch –up annually over 10 years is a lot of money. Where will we find the money? Cut from Mental Health? Hospitals?”

(l) “There are many, many groups in similar situations that have not received increases for 10 or 12 years.” He mentioned community nurses have not received increases in 5 years.

51. Following this meeting, the MOHTLC did not move to establish a process to review and resolve the issue of inequitable compensation. The AOM became very concerned as the time was closing in on the finalization of budgets for the 2005/2006 fiscal year.

52. In subsequent communications with the MOHLTC, the AOM continued to press the MOHLTC to ensure that those carrying out the Government’s primary care reform agenda were paid equitably based on the value and contributions of their work. While we recognized the importance of growth of the profession through funding of further new registrants, we also told the Ministry that the government needed to invest in sustaining the profession by providing equitable compensation. This would also serve to address the government’s agenda for cost effective delivery of health services which emphasized community-based and collaborative care.

53. In a letter dated November 11, 2004, I wrote to Minister Smitherman that midwifery compensation needed to be addressed:,

(a) I once again expressed concerns with future recruitment and retention of midwives if they continued to be inappropriately compensated for the value they provide. I had personally heard from many midwives who were making plans to leave the profession because it was not financially sustainable for them.

(b) I provided information about the value of midwives, citing a savings to the health care system of $1800 per midwifery home birth. I also cited the

Ministry's 2003 survey[56]of midwifery consumers that found a 98.7% satisfaction rate with midwifery care.[57]

(c) The fact sheets we created and attached to the letter addressed many of the issues that we had been raising throughout negotiations, including the positive outcomes when primary healthcare providers work as a cohesive team (for which parity is essential), the attrition rate of midwives due to low compensation, and the necessity of increasing compensation for midwives, given the financial costs of their irregular, on call schedules and the additional administrative burdens that their work requires.

54. On November 11, 2004, the AOM wrote to every MPP in the province, describing the many benefits that midwives bring to the healthcare system and urging them to support increasing midwives compensation and attached the above-noted letter to the Minister which attached fact sheets on midwifery. [58]We had many favourable responses from MPPs across Ontario.[59]

55. On November 19, 2004, at my request, AOM Consultant Domino had a phone call with Ministry staff—Esther Sheinbaum and David Spencer—to get action on the AOM's compensation. I was advised that the Ministry's response was that they were engaged in OMA negotiations and midwives would need to wait for that outcome. They stated that they wanted to work with the AOM but the AOM would need to be patient.[60]

56. Frustrated with the lack of progress in negotiations, I wrote to Jason Grier, Executive Assistant to the MOHLTC Minister on November 24, 2004 to request a clear response to our request for equitable compensation and timely negotiations.[61] The letter set out that the AOM would be holding a media conference on December 14, 2004.[62] The letter stated: "We have been waiting

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

57 Package of Materials prepared by AOM for MPGs to meet with MPPs re: Background Information about Midwifery and Benefits to the Health System attaching multiple Fact Sheets,.(November 11, 2004), AOM0005927.

58 Package of Materials prepared by AOM for MPGs to meet with MPPs re: Background Information about Midwifery and Benefits to the Health System attaching multiple Fact Sheets,.(November 11, 2004), AOM0005927.

59 Series of Letters and Articles re: 2005 Contract Negotiations, including correspondence between E. Johnson and T. Arnott, E. Johnson and E. Witmer, E. Johnson and P. Kormos, and T. Arnott and G. Smitherman, (November 11, 2004), AOM0002413.

60 Email from Leonard Domino to President Elana Johnson and AOM Alison Dantas, (November 19, 2004), AOM0000794.

61 Letter from E. Johnson (AOM President) to J. Grier (EA to the Minister of Health) re: public campaign, (November 24, 2004), AOM0001848.

62 Letter from E. Johnson (AOM President) to J. Grier (EA to the Minister of Health) re: public campaign, (November 24, 2004), AOM0001848.

since early summer for a response to our compensation proposal. Repeatedly, the Ministry staff designated to work with us agree to meeting dates and then cancel them at the last minute with no plausible explanation."[63]

7. Increased Media and Political Attention

57. During the negotiations in the summer and fall of 2004, the AOM started to reach out to the media. There were a number of articles written on the importance of midwifery in Ontario newspapers.[64]

58. On November 27, 2004, Margaret Phillip published an article in the Globe and Mail entitled "Midwives in Ontario set to begin job action" in which a Ministry spokesperson was quoted as saying that Smitherman had not promised midwives any raises. [65] The AOM was furious, because we felt that this indicated that throughout our intense negotiations over the past several months, the government had been negotiating in bad faith.

59. On December 7, 2004, Michael Krauss sent me an email advising me that in question period on December 6, 2004, MPP Shelley Martel asked Minister Smitherman why he had not yet addressed the requests for equitable compensation for midwives. Smitherman replied:

> *"I'd be clear in saying to the honourable member, as I have to midwives themselves, that their expectation of having an immediate catch-up for the period of time that the previous government and the latter year of your party's government didn't increase their funding was not reasonable. Having said that, I continue to be of the opinion that we need to do more to hire more midwives in Ontario and do look at compensation issues, and that's exactly what we're in the midst of doing"*[66]

60. On November 26, 2004, I was copied on a letter that the three Directors of the MEP at Ryerson (Judy Rogers), McMaster (Karen Kaufman) and Laurentian (Susan James) wrote to Minister Smitherman. They made the following remarks in their letter:

(a) Expressed their "grave concern about the lack of response of your Ministry to achieving a new midwifery compensation agreement"; stating that it "directly threatens the growth of the profession and the development of midwifery in

63 AOM Internal Document Tracking Meetings re: 2004 Contract, (October, 2004), AOM0001768.

64 Article, The Birth of a Dilemma, from Globe and Mail re: Growth of Midwifery, (October 16, 2004), AOM0003062.

65 Article, Midwives in Ontario set to begin job action, <http://www.theglobeandmail.com/news/national/midwives-in-ontario-set-to-begin-job-action/article1007848/>, (November 27, 2004), AOM0017365.

66 Email from M. Krauss to A. Dantas, E. Johnson, M. Heitshu re: Midwifery Questions in yesterday's Hansard, (December 7, 2004), AOM0002440.

Ontario"; has "lead to an erosion of actual incomes and more importantly an erosion in morale of midwives";

(b) This has had an effect on our profession in terms of attrition and the willingness of midwives to take on additional teaching and clinical responsibilities";

(c) "compensation is not sufficient to provide an attractive option when compared to physicians, nurse practitioners, or even senior nurses, all of whom undertake considerably less on call commitments;"

(d) any job action by the AOM will severely disrupt the education year and "will cause financial hardship to students who already incur a tremendous financial burden in completing the midwifery program without the ability to work part-time due to the on call demands of the midwifery clinical placement"; and

(e) that the midwifery profession must be able to "attract highly qualified applicants" and "must have the ongoing contributions of midwifery preceptors to the education of our current students". [67]

8. Storks Don't Deliver Babies Campaign, December 2004

61. In the face of the Ministry delays around negotiations and increasing concerns about attrition, the AOM launched our "Because Storks Don't Deliver Babies" public campaign.[68] This campaign included the practice of midwives calling their MPP offices each time they were called out to visit their clients, even if it was in the middle of the night. Midwives left messages saying that they were going to attend a birth or attend to urgent clinical work that they were not being properly compensated for.[69] [70] We also encouraged midwives to schedule urgent meetings with their MPPs to discuss the need for increased compensation. Midwifery consumers were also engaged in this campaign[71] and provided communications supporting the AOM request.[72]

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67 Letter from Directors of MEP to G. Smitherman, E. Johnson copied, re: Compensation, (November 26, 2004), AOM0002432.

68 Sequence of Actions for Storks Don't Deliver Babies Campaign, (November 1, 2004), AOM0006279.

69 FAQ by AOM re: Storks Don't Deliver Babies Campaign, (November 29, 2011), AOM0006278.

70 Instructions by AOM to AOM Members re: Pager Campaign for Storks Don't Deliver Babies, (November, 2004), AOM0006274.

71 Bulletin by AOM to AOM Supporters re: Storks Don't Deliver Babies Campaign, (December 1, 2004) AOM0006280.

72 Letter from S. Kolomeitz-Warman to G. Smitherman re: Storks Don't Deliver Babies Campaign (March 19, 2005) AOM0002499.

62. The AOM also drafted a template letter dated December 3, 2004, to be sent by AOM members to George Smitherman. The letter expressed frustration with the recent Globe and Mail article, in which a MOHLTC spokesperson told the paper that "there was no promise of an increase" to midwives. The letter also demanded fair compensation for midwives.[73]

63. The campaign got some attention, but the government was still unwilling to increase our compensation.

64. We did have a further meeting with ADM Zegarac at the MOH offices on December 9, 2004 Sue Davey was at this meeting. I presented to them the plight of many midwives who felt an urgent pressure to decide whether to stay in the midwifery profession because of the increasing difficulty they were experiencing in being able to afford to pay for their family expenses including child care and care for elderly relatives. I advised that the lack of fair compensation was causing serious recruitment and attrition concerns.[74]

65. At this meeting, Zegarac first said maybe we should do a child care program. I said that would not address the problem of those who had elderly parents, other dependants or had other financial pressures. Zegarac said that we can't make up for 10 years of no compensation increases in one round of compensation discussions. He stated that the problem was the government was engaged with a number of parties in negotiations. He stated that we would not get money we were asking for but trying to do something. He said while our members might get something, public message has to be different.

66. According to Davey, following the meeting, Zegarac said "we need to do something"

67. As the Ministry kept telling us there was no money to address our equity concerns, over this time period, we witnessed physicians enjoying increases in compensation including CHC physicians. One big problem was that it seemed clear that the next step was some kind of job action, but midwives were very averse as a matter of principle to withdraw or compromise the care services they were providing to their current clients. As well, the College of Midwives of Ontario standards required that they not take any action which would jeopardize client care. That is, job action could result in disciplinary action by the regulator. Job action would also impact students in the MEP, which was a serious concern for them and their instructors, as noted above.

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73 Template Letter by AOM for AOM Members to G. Smitherman re: Response to Globe and Mail Article re: Storks Campaign (December 3, 2004) AOM0006277.

74 December 9, 2004: Notes from Meeting with George Zegarac (December 9, 2008) AOM0002591.

68. Had the government not provided an offer on December 13, 2004, the next escalation for the AOM would have been to cease taking new patients for the month of January, and to name the month "Smithermonth."[75]

9. MOHLTC Offer, December 13, 2004

69. Frustrated by the lack of movement, the AOM Board decided to move ahead with a campaign rally and press conference on December 14, 2004, that was to be covered by the CBC and was intended to publicize the struggle of midwives.

70. Immediately before the rally was to begin, on December 13, 2004, the OMP Program Coordinator Wendy Katherine called me and advised me that the government was prepared to put the following money on the table, if the rally was cancelled:

(a) increase in total midwifery program budget of $5.3 million in 2005-06;

(b) $8.0 million in 2006-07; and

(c) $9.0 million in 2007-08.

71. This was to include money for the expansion of midwifery positions, increased compensation and other infrastructure costs. Katherine did not state what the breakdown of the amount would be. She also told me that the total amount was basically not negotiable.

72. The AOM cancelled the rally and press conference[76] when it received an offer in writing from ADM Zegarac on December 13, 2004.[77]

73. Wendy Katherine claimed that the MOHLTC had to “run the numbers”. It was difficult to determine how much the lump sum actually would translate into compensation for midwives. The Board and I felt that we needed to move forward and work with the Ministry’s pre-determined limit in order to get money into the pockets of our membership. In any event, we recognized that the Government controlled the budget and had made it clear that budgeted amount was final and they were not prepared to move from it. As well, this was the first time since the regulation of midwives, 10 years on, that the Government had actually concretely proposed money to address the inadequacy of midwifery compensation. While the overall budgeted amount was fixed, there had not yet been any determination

75 Letter from E. Johnson to AOM Members re: Storks Don't Deliver Babies Campaign (December 10, 2004) AOM0006276.

76 Fax from Elana Johnson to All AOM Members re: Press Conference Cancelled, (December 13, 2004), AOM0006273.

77 December 13, 2004 - Letter from George Zegarac to Elana Johnson (original slanted) (December 13, 2004) AOM0001844.

as far as we knew as to how that money was to be divided up within the Program budget and how much could go to compensation adjustments.

XII. 2005 THE MOHLTC-AOM TPA FUNDING AGREEMENT

1. Negotiations regarding the MOHLTC-AOM TPA Funding Agreement

74. Subsequent to the MOHTLC tabling of its overall financial commitment on December 13, 2004, in the winter of 2005, the AOM and the Ministry continued to meet to discuss compensation and the terms of the funding agreement. As a result of the CHPB's fiscal mandate, the discussions were driven by the finite, non-negotiable amount of money that could be allocated, which was decided by the MOHLTC before the discussions began.

75. I was involved in these negotiations. Negotiations were directed by the Funding Reference Group, which included midwives Kristy Hook, Maureen Silverman, Jenn Wright, Remi Ejiwunmi, Bobbi Soderstrom Anne Wilson and AOM Executive Director, Alison Dantas. When we negotiated with the OMP, the only people who were there were myself and Alison Dantas and Sue Davey and Wendy Katherine for the OMP. [78]

76. These discussions revolved around how to distribute the fixed funding amounts promised by the government that had been allocated for the years of the contract.[79] They included discussions with respect to on call payments, the collapsing of the levels of payment grid, the expansion of the profession and incentives.[80] [81] The money they had allocated was not just for compensation, but for operational funding as well. Throughout these negotiations we also communicated regularly with the Board and with our membership.[82] [83] We also received feedback from the membership regarding the offer that we accounted for and tried to integrate into our negotiations.[84]

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78 Agenda - AOM Funding Reference Group, and Key Negotiating Positions attachment with notes, for Jan. 17, 2005 meeting(January 17, 2005) AOM0002570.

79 Estimate of Current OMP Position, OMP Scenario 2 Including Second Midwife Fee (February 20, 2005-March 2, 2005) AOM0002634.

80 Impact Assessment: OMP Budget Impact. Impact of 2005 Funding Agreement on OMP (March, 2005) AOM0002635; OMP Compensation Scenario Figures (March, 2005) AOM0002632.

81 Email between A. Dantas and M. Heitshu re: info from W. Katherine / compensation (January 10, 2005) AOM0002507.

82 Description of Compensation Offer to Members from AOM (May 1, 2005) AOM0001385.

83 Compensation Questions & Answers, AOM Member Communication re: 2005 Contract (2005) AOM0002631.

84 Email from J. Dempsey to AOM re: Concerns with Compensation Offer (January, 2005) AOM0002578.

77. While Sue Davey and Wendy Katherine pushed hard for a 2% compensation increase, we opposed such a low adjustment as we knew it was wholly inadequate to address our inequitable position in relation to our health care comparators.[85]

78. Throughout the meetings, Davey insisted on no formal minutes being taken. By the AOM-OMP meeting on February 23, 2005, the AOM and OMP proposals were beginning to become more harmonized.[86] The AOM's goal was always to make the compensation structure as equitable as possible for all midwives, including those in rural practice and those with fewer years of experience. [87]

79. Once the AOM and the OMP had sufficiently negotiated the details of the MOHLTC's offer, the offer would be put to a vote so that the membership could ratify it. The ratification process was brought to the Board on March 3, 2005, for approval, in anticipation of an acceptable offer.[88]

80. In March 2005, the Ministry offered the AOM a one-time 20% increase in compensation, effective April 1, 2005. The Ministry was not prepared to consider any prior retroactivity date. The proposal also did not address the fact that the midwives were still not in an equitable relationship to the CHC physician compensation structure.

81. The Ministry's final compensation structure collapsed the levels of payment from 12 to six with the start rate at $71,600 and the top rate of $92,600 in the first year, increasing to a range of $74,600 to $96,400 in the third year. The movement to the six levels was phased in over the three year term of the agreement. This included an on-call payment of $300 per BCC as well as a retention incentive only for level six and a secondary care fee. The benefits were increased to 18%. There were also some increases with respect to operational expenses. [89]

82. As a result of the compensation increase, the Ministry increased the course-of-care fees for each midwife by 20% to 29%, depending on the grid step, but prohibited midwives from moving up experience levels over the course of the 2005 to 2008 contract. This resulted in each midwife receiving a one-time increase in 2005 to her compensation over the duration of her contract. She did

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85 Update on Compensation negotiations; meeting with S. Davey and W. Katherine, (January 31, 2005), AOM0002509.

86 Comparison of AOM and OMP Compensation Proposals (February 23, 2005) AOM0002602.

87 Analysis of February 28 AOM Alternate Compensation Scenario (February 28, 2005) AOM0002601.

88 Report for AOM Board re: Compensation Approval Process, for March 3, 2005 meeting (March 3, 2005) AOM0002517.

89 AOM-OMP Communications Summary, discussion document (2005) AOM0002610.

not move up the grid during this period as the grid was frozen, which represented an economic loss for each midwife.[90]

83. The Ministry did not provide any justification as to:

(a) why it chose $92,600 as the job rate for midwives, when the Hay report advised that this job rate should be $103,000; or

(b) why it offered an on-call rate of $300 to the midwives, when the Hay report advised that this figure should be $550.

84. The Ministry did not collapse the grid to one rate as proposed by the Hay report and argued for by the AOM. [91] Sue Davey and the OMP were adamant that they would not implement a single job rate in that round of negotiations and that they were contemplating 5-8 levels of fees for midwives for that round of talks.[92] She stated it was essential that there be recognition for experience. This was despite the fact that the CHC physician did not have that number of steps and the family physician and obstetrician/gynecologist were paid one fee regardless of level of experience and Hay had stated that it was inappropriate and unusual for an independent contractor. As well, newly hired CHC physicians generally are started at the maximum rate of their pay grid (since the CHC receives funding based on the maximum rate) whereas the Ministry TPA MPG agreement requires midwives to be placed on their grid strictly according to years of experience..

85. After many negotiation meetings where we argued for more equitable compensation terms, we finally decided that there was no alternative at that time but to stop further disputing the Ministry's position, given its intransigence.

86. The government's funding position was then set out in a new Transfer Payment Agency-Midwifery Practice Group Funding Agreement that would be effective from April 1, 2005 to December 31, 2007.[93] This agreement was finalized July 2005.

87. The negotiations felt like they were starting to take our struggle and our relationship with the government in a better direction. However, we still realized that there was still a very large pay gap to be addressed and that midwives were a long way from equity to other primary care providers.

88. On March 22, 2005, I wrote a letter to the membership explaining the details of the offer, and advising the membership that it was the best we felt we could do

90 Description of Compensation Offer to Members from AOM (May 1, 2005) AOM0001385.

91 Proposed Collapsing of Levels, AOM proposal (2005) AOM0002617.

92 Key Negotiating Positions, AOM document (January 11, 2005) AOM0002501.

93 Draft funding agreement between TPA and MPG (July 1, 2005) AOM0000615.

given the fiscal constraints and political imperatives. [94] This letter attached the "Description of the Offer" and "Compensation Q & A". make sure document attached.

89. In response to that letter to the membership, the AOM received some feedback from midwives, concerned about some of the details of the compensation proposal, including the absence of particulars. [95] [96]

90. The AOM Board and Benefits Committee also sent a memorandum to the membership on April 5, 2005, detailing the impact of the compensation offer on midwives' benefits.[97]

2. Use of Term "Negotiation"

91. After months of negotiations between the AOM and the OMP, after the agreement was ratified, Wendy Katherine wrote to Michael Heitshu with concerns about using the term "negotiation"?[98] [99]

> I was puzzled when I heard this and dismayed. In fact, the MOHLTC had used the term negotiate in every meeting we have had with them- from the ADM George Zegarac on down and was very puzzled that now the Government did not want the term put in writing. As our members empower us to represent them, I was upset that the MOH cannot acknowledge the role entrusted to us by the membership. As well, I did not understand how parties could arrive at an agreement, except by negotiating with the representatives of both parties to reach an agreement.[100]

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94 Memo to AOM members re offer from MOH with summary of offer (March 22, 2005) AOM0001387.

95 Letter from Midwives Grey Simcoe, Barrie Midwives, and Midwives*Sages-Femmes of North Bay to E. Johnson re: Compensation Offer (March 28, 2005) AOM0002527.

96 Email chain between E. Abbey, M. Heitshu, A. Dantas, A. Crabbe, A. Wilson, C. Goodrich, D. Smith, E. Thomas, E. Johnson, H. Rall, J. Wright, K. Kilroy, K. Hook, L. Weston, M. Silverman, copying D. McNab, re: Compensation Package Sent Out, and attached feedback letters from midwives (March 29, 2005) AOM0002525.

97 Memo from AOM Benefits Committee to Members re: Benefits and Compensation Offer (April 5, 2005) AOM0002535.

98 Email chain between B. Soderstrom, R. Ejiwunmi, copying AOM staff/board re: Shared Principles Document (May 1, 2005) AOM0002533.

99 Email chain between E. Johnson, B. Soderstrom and R. Ejiwunmi, copying AOM staff / board re: shared principles of negotiations. (May 3, 2005) AOM0002530.

100 Email from B. Soderstrom to E. Johnson and M. Heitshu re: use of the term negotiate (June 6, 2005) AOM0002492.

3. Ratification of the MOHLTC-AOM TPA Funding Agreement

92. On May 27, 2005, the AOM received a letter from Wendy Katherine, with a final draft of the Midwifery Practice Group Transfer Payment Funding Agreement. [101][102]

93. I forwarded to the membership a memorandum dated May 30, 2005[103] which attached a document, **"**Description of Compensation Offer to Members from AOM "*. My memorandum noted that we were still working out final agreements with the Ministry.*

This Document stated in part as follows:

In December, the Ministry offered to increase the total current midwifery program budget by $5.3 million for 2005/06, $8.0 million in 2006/07 and $9.0 million in 2007/08. The total amount of money did not significantly change between the Ministry's offer to us in December 2004 and now. The primary challenge for the negotiating team has been to develop a fair compensation offer within the amounts offered by the Ministry at that time, as well as other Ministry objectives. That's what we have been negotiating. It is our understanding that this will cost the Ministry slightly more than they originally offered in 2005/06 and 2006/07, and exceeds the initial offer by about $500,000 in 2007/08. In each of the three years, the Ministry has indicated the available funding has to be used to fund the difference between the current scale and the new scale for current practitioners and those joining the profession. Because we were working with a fixed amount of funding, the negotiating team explored many different trade-offs, knowing that an increase in any one area would have resulted in decreases in other areas. [104]

94. By letter dated June 28, 2005, Sue Davey wrote to me confirming the conclusion of the review of the new agreement and the parties' agreement to revisit the agreement no later than December 31, 2007 or earlier if there is a substantive change in the workload involved in the midwifery course of care. [105] The finalized funding agreement was dated July, 2005 and ready to be voted on finally by the membership.[106]

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101 2005/05/27 - Discussion Draft of TPA-MPG Agreement (May 27, 2005) AOM0005689.

102 Letter from W. Katherine to M. Heitshu re: Funding Agreement for review (May 27, 2005) AOM0002497.

103 Memorandum From Elana Johnson to all Voting Members (May 30, 2005) AOM0002496.

104 "Description of Compensation Offer to Members from AOM" (May 1, 2005) AOM0001385.

105 Letter from MOH Sue Davey to AOM Elana Johnson enclosing the sign back template agreement for 2005-2006 to implement the three year fee and operational funding increase (June 28, 2005) AOM0009405.

106 Agreement between MOH Sue Davey and AOM Elana Johnson re: Review of TPA-MPG Agreement if substantive change in workload (June 28, 2005) AOM0009406.

95. On June 29, 2005, on behalf of the Funding Reference Group, I sent the updated draft of the Funding Agreement to all members and the voting package which included instructions for voting. [107]

96. On July 11, 2005, we held a board meeting and decided that we would recommend the contract's terms, even given its great shortcomings and the refusal of the MOHLTC to address our full equity demands. On July 12, 2005, the AOM staff hosted two teleconferences to explain the conclusions of the Board meeting and answer any questions the membership may have.

97. On July 13, 2005, I wrote a letter to the membership on behalf of the board acknowledging that the Funding Agreement was far from perfect, but recommending that the membership ratify it as a significant step forward for midwives.[108]

98. Minister Smitherman faxed me a letter on August 8, 2005 confirming the funding for increased compensation. The letter noted that midwives were playing an "increasingly important role" in ensuring women were receiving the primary health care they needed during pregnancy, labour and birth.[109]

99. That same day, Minister Smitherman announced that the Ministry would be investing a further $13.8 million of funding for 50 more midwives across Ontario. This funding is “so that 50 new midwives can begin practising in Ontario this year and the government can cover the costs of increased midwifery fees and operating expenses for all registered midwives.” [110]

100. On August 19, 2008, the Ministry issued a news release "McGuinty Government Improves Access to Midwifery Services," referring to the increased funding for program expansion it states, “the new funding will also cover the cost of an increase in midwifery fees and operating expenses, resulting from a new agreement last December between the government and the Association of Ontario Midwives.” [111]

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107 On behalf of the Funding Reference Group, I sent the updated draft of the Funding Agreement to all members: Memo from E. Johnson to AOM Members re: New Funding Agreement and Approval Process (June 29, 2005) AOM0010019.

108 Memo from E. Johnson to AOM Members re: Funding Agreement Approval (July 13, 2005) AOM0010017.

109 Letter from Hon. G. Smitherman (Minister of Health and Long-Term Care) to E. Johnson (AOM President) re: additional funding to the Ontario Midwifery Program (August 8, 2005) AOM0000681.

110 Backgrounder: Expanding Midwifery Services in Ontario. Announcement from MOHLTC (August 8, 2005) AOM0001759.

111 MOHLTC News Release, McGuinty Government Improves Access to Midwifery Services, with attachment (August 19, 2004) AOM0001764.

101. However, the Ministry still did not engage in any compensation review or pay equity/human rights analysis, nor fully engage with the issues raised by the Hay Reports and explanatory documents

XIII. COMPARISON TO MOHLTC APPROACH TO CHC PHYSICIAN COMPENSATION

102. In contrast to the MOHLTC refusing to properly align in relation to the value of the work the work of midwives and their comparator, the CHC physician, the Ministry was still busy working on implementing the large increases it had negotiated with the OMA for CHC physicians.

103. The MOHLTC had agreed with the OMA to harmonize compensation for Community Health Centre (CHC) physicians with that of physicians in other aligned models of primary health care. This was stated to be because Community Health Centres are an important part of the Primary Health Care Renewal Strategy. Midwives were also clearly part of that Strategy but there was no effort by the MOHLTC to align appropriately based on the value of their work the compensation of midwives and CHC physicians as had been done by the government in 1993 by the Joint Funding Work Group and Morton report.

104. This required enormous effort by the MOHLTC to realign the compensation of previously salaried only CHC physicians with the fee for service and incentive based primary care physicians in FHTs

    (a) CHC physicians received adjustments back to 2003.

    (b) CHC physicians were also provided with additional 2.41% base adjustments as per the 2004-2005 OMA agreement. These changes resulted in the following new salary scales retroactive to April 1, 2004 (in addition to the on-call payments:

        (i) Non-underserviced communities - $113,265 to $136,455 plus a one-time $4660 in salary linked adjustment payments;

        (ii) Northern/underserviced communities - $143,580 to $172, 975 plus a one-time $4660 in salary linked adjustment payments

105. The CHC physicians were also now entitled to 25% in benefits and relief.

106. As well, the above OMA agreements provided that the CHC physicians also received increases in the following years as follows:

    (a) July 1, 2006, 0.11%

    (b) October 1, 2006, 1.16%

    (c) January 1, 2007, 0.67%

107. There were other inequities between CHC physicians and midwives. For example, while midwives continued to work in the same underserviced areas as CHC physicians, they were not compensated for this feature. In contrast, CHC physicians received more money as a result of being placed on the higher underserviced CHC wage grid.

108. In 2005, the MOHLTC announced that it was creating 150 new Family Health Teams over the next four years, further demonstrating its commitment to funding physicians.[112]

109. As well the MOHLTC was also providing additional funding to create many new Community Health Centres across the province, expanding physician services while concurrently providing substantial compensation increases for our comparator, the CHC physician - the very thing MOHLTC told the AOM it could not do. The MOHLTC had agreed in its agreements with the OMA to "align" the CHC physicians with other fee for service primary health care family physicians in organizations such as Family Health Teams. While the MOHTLC expended a great deal of energy and time to make these comparisons and align the CHC Physician's pay, they were not willing to make the comparisons we had asked for between midwifery and the CHC physicians and nurse practitioners as set out in the Hay Report.

Even though some progress was made in our 2005 negotiations, we felt our female dominated profession was still being very unfairly treated – particularly in relation to our comparator, the male dominated CHC physician.

XIV. INCREASING VALUE OF WORK OF MIDWIVES

1. Introduction

110. Over this time, the problem was exacerbated by the fact that the value of the midwives' skill, effort, responsibility and working conditions increased while the CHC physician's pay was also substantially increasing.

2. Scope of Practice of Midwives and Physicians

111. Over the period 2006 to 2008, the value of midwifery work continued to grow as summarized in the Durber report. This included the work detailed in the AOM 2007 workload analysis based on a survey of midwives.[113] As well, during this period, the specialized skills the midwives had were increasing as they were now able to assists at C-sections, amongst other matters which are detailed in the Durber report - Annex 5 B and Annex 7.

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112 Press Release from MOHLTC re: Family Health Team Applications (February 16, 2005) AOM0002506.

113 Association of Ontario Midwives, "Ontario Midwifery Workload Study 2007" (2007) AOM0005588.

112. As a result of the CMO change which allowed properly trained midwives to do C-section assists, some midwives, particularly in rural areas, began to do this. Yet midwives have never been paid for this service, despite requests from the AOM to develop a funding mechanism for this additional specialized skill.

113. In April of 2006, the Health Professions Regulatory Advisory Council (HPRAC) submitted advice to the MOHLTC in a report entitled "Regulation of Health Professions in Ontario: New Directions."[114]

114. On July, 14, 2006, the AOM submitted a response to HPRAC's report, in which we detailed our concerns about it.[115]

115. The 2006 Provincial Perinatal Report was released and again detailed the excellent health outcomes that midwives were achieving for women and their newborns.[116] As well, during that year, the Ministry released data that showed midwives continued to produce excellent outcomes on a number of maternity care indicators.[117]

116. The September 6, 2006 report from the Ontario Maternity Care Expert Panel – Emerging Crisis, Emerging Solutions ("OMCEP") detailed the importance of valuing maternity care providers, the rising intervention rates, the need to expand the scope of practice of midwifery and the escalating crisis of shortages in such providers.[118] Vicki Van Wagner, Judy Rogers and I were members of this expert panel that contributed to this report, and Van Wagner, Rogers and the OMP's Katherine were among its writers. However, unfortunately, the report was never formally adopted by the government.

3. Physician Attempts to Restrict Midwifery Scope of Practice

117. During this period of time, there were ongoing attempts by physicians to control and restrict the practice of midwifery and complain about physician compensation relative to midwives.

118. In 2007, the OMA issued its Policy on Maternal and Newborn Care. This paper provided erroneous and inflammatory information regarding the difference

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114 The Health Professions Regulatory Advisory Council (HPRAC) report entitled "Regulation of Health Professions in Ontario: New Directions." (April 27, 2006) AOM0017364.

115 AOM a response to HPRAC's report "Regulation of Health Professions in Ontario: New Directions." (July, 14, 2006) AOM0017396.

116 Tailoring Services to Pregnant Women and their Babies in Ontario - R2006 Provincial Perinatal Report by Provincial Perinatal Surveillance System Subcommittee (2006) AOM0000651.

117 MOHLTC Presentation to APHEO Conference re: Ontario Midwifery Program and Ontario Midwifery Clinical Database (October 16-17, 2006). AOM0000603.

118 Ontario Women's Health Council, "Executive Report of the Ontario Maternity Care Expert Panel: Emerging Crisis, Emerging Solutions", (September 6, 2006) MOH026149.

between physician and midwifery compensation, stating that midwives were better paid than physicians. This policy was published in the Ontario Medical Review in October 2007 and circulated to all OMA members, as well as stakeholders, such as the MOHLTC. Among other efforts, I drafted a letter to the Editor of the Ontario Medical Review clarifying the reality of midwifery compensation which was printed in their April 2008 edition of the Ontario Medical Review.[119]

119. I also drafted a letter to Minister Smitherman to alert him to the issue on November 9, 2007.[120] As a result of the efforts by the AOM, the OMA issued a Revised OMA Policy on Maternal and Newborn Care in February 2008.

120. This hostile position of some physician lobby groups toward midwives is further evidenced by the Ontario College of Family Physicians (OFCP), OMA and SOGC submissions to the Health Professions Regulatory Advisory Council ("HPRAC").[121] The CMO and AOM made submissions to the HPRAC Advisory Council on the issue of inter-professional collaboration and the barriers facing midwives in that regard.

121. In August 2008, HPRAC issued its report, Inter-Professional Collaboration – Scope of Practice Review: Midwifery. This report noted the key findings of the Multidisciplinary Collaborative Maternity Care Project Background Research ("MCP2"). It also cited the findings of the above-noted OMCEP Report.[122]

122. Around this same time the Canadian Medical Association introduced a statement/position paper that stated that only physicians were appropriate leaders for collaborative care models and trying to restrict the scope of practice of other professions.[123] The OMA paper on inter professional care[124] which was also issued around this time suggested that only physicians should be allowed to admit patients to hospital (14 years after midwives had been given their authority

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119 Letter from E. Johnson to OMR Editor re midwife compensation (2008-04-01) AOM0001554.

120 Letter from E. Johnson (AOM President) to Hon. G. Smitherman (MOHLTC) re: Interprofessional Maternity Care (November 9, 2007) AOM0010310.

121 Submission from the Ontario College of Family Physicians (OCFP) to The Health Professions Regulatory Advisory Council (HPRAC) In Respect to The College of Midwives of Ontario Scope of Practice Review (August 15, 2008) AOM0000643.

122 Health Professions Regulatory Advisory Council's Report titled "Scope of Practice Review - Midwifery: Summary & Selected Highlights from the Literature", (August 2008) AOM0000605.

123 Putting Patients First: Patient Centred Collaborative Care, A Discussion Paper, Canadian Medical Association (July 2007) AOM0017367.

124 Interprofessional Care, A. Hanna, OMA Health Policy Department, Ontario Medical Association (2007) AOM0017366.

under the Public Hospitals Act). This was more evidence of physicians trying to control and be the gate keepers of the health care system.[125]

XV. ONGOING INCREASED COMPENSATION FOR CHC PHYSICIANS

123. In May, 2007, the Primary and Community Care Committee (PCCC) approved the interim and retroactive incentive payments in addition to the above salary increases, to be paid to CHC physicians in accordance with the incentive payments provided for in the OMA 2004 agreement which were then implemented by the MOHLTC. These incentives included:

Interim Payments (April 2007 to March 2008):

- Interim payment for Comprehensive Care Management (CCIvI) based on achievement of 60% of enrollable clients
- Additional payment of $7000/FTE related to projected pooled value of incentive and bonus claims
- The interim payments in 2007-2008 replaced the $4660 paid in previous years.

Projected Value: $17,936/FTE

Retroactive Payments (October 2005 to March 2007):

- Interim payment for Comprehensive Care Management (CCM) based on achievement of 60% of enrollable clients
- Additional payment of $2340/FTE related to projected pooled value of incentive and bonus claims (differential between $7000 and previous payment of $4660/FTE)
- Projected Value: $20,664/FTE.

XVI. 2007: MIDWIFERY WORKLOAD ANALYSIS

124. In accordance with the AOM MOHLTC 2005 agreement to re-open the agreement if there was significant change in workload, the AOM decided to carry out its own workload analysis. The AOM hired a firm E. Dean & Associates in 2007 to work on the project. We decided that the project would be supervised by the AOM's Director of Policy and Communications, Juana Berinstein and that the firm would also work closely with me.

125. At time of regulation, the workload analysis relied upon by the AOM and the MOHLTC in their negotiations was the analysis set out in Van Wagner's pre-regulation 1991 thesis, With Women: Community Midwifery in Ontario. This figure was 48.25 hours per course of care. However, much had changed over the 16 years since that analysis.

125 CMSJ Canada's doctors assail pharmacist prescribing, August 22, 2007, (August 22, 2007) AOM0017348.

126. E. Dean first conducted extensive background research and surveyed the methodology options. [126]

127. An extensive survey was conducted in 2007 with Ontario midwives charting their time spent in providing midwifery services, including their increasing practice management and reporting responsibilities.[127] Midwives were all given a Daily Time Summary Sheet, upon which they were asked to document their days. [128] There were a number of supporting documents. [129]

128. The Workload Survey arrived at an estimate of 55.83 hours per course of care. The consultants found that many clinical and non-clinical responsibilities had been added to the work of an Ontario midwife since 1993 such as: arranging IPS Genetic Screening; more informed choice discussions regarding, group B streptococcus, glucose screening, vaginal birth after C-section, and Vitamin K; administering home births infant health cards; increased provincial privacy requirements; increased requirements for invoicing; challenges in obtaining hospital privileges for practice members; changes to accountability requirements from the province; changes to head midwife administration, monitoring and securing of infant health cards. The consultants reported the following differences in workload between the 1993 benchmark set by the Ministry and the work of midwives in 2007:[130]

	1993 **(Hours per client)**	**2007** **(Hours per client)**
Prenatal	13.25	13.42
Labour & Birth	19.0	17.1
Postpartum	11.0	11.45
Practice Support/Administrative	5.0	13.86

126 "Report of Phase 1 Workload Analysis: Next Steps" - Presentation by E. Dean & Associates (March 12, 2007) AOM0005783.

127 User Manual for AOM Workload Survey (July 3, 2007) AOM0005806.

128 Workload Analysis Midwife Time Tracking Sheet (May 5, 2007) AOM0005775.

129 AOM Workload Analysis Survey re: Weekly Estimates, (2007) AOM0005568; AOM Workload Analysis Survey re: Clinical Activities (2007) AOM0005569; Workload Analysis Draft Appendix G (2007) AOM0005570; AOM Change in Workload Survey (2007) AOM0005574; Survey Instrument Tracking Tool for AOM Workload Analysis (2007) AOM0005576; Workload Analysis Summary Table (2007) AOM0005579; Summary of Non-Clinical Workload Analysis Results (2007) AOM0005580; Draft Results from Non-Clinical Workload Analysis Survey (2007) AOM0005602.

130 Report by the AOM: re Finding of 2007 Midwifery Workload Study (2007) AOM0005588.

TOTAL	**48.25**	**55.83**

129. The consultants found that midwives were working approximately 7.5 hours of unpaid work per client ("per course of care") in 2007 compared to 1993. While the prenatal, labour and birth and postpartum hours had stayed relatively consistent, the survey found that the administrative burden on midwives had increased significantly.

130. The AOM relied in part on this 2007 workload survey and analysis[131] to request a compensation increase given the significant increase in workload since 1993.

131. December 31, 2007 came and went without the MOHLTC meeting its contractual commitment from the 2005 contract to start negotiations by that date.

XVII. 2008 AOM MOHLTC CONTRACT NEGOTIATIONS

132. On July 25, 2007, I received a letter from George Smitherman stating that the government approved additional $12.3 million in midwifery funding to expand the program with increased students MEP students positions up to 90 from 60 students and other enhancements, bringing the total OMP funding to $76.2 million in 2007/2008. However, the letter made no mention of compensation.[132]

133. I drafted a follow up letter on September 6, 2007 to John McKinley, the ADM of the Health System Information Management Division. While the AOM was pleased with the above-noted expansion of the program the MOHTLC was still not addressing our need for equitable compensation.[133]

134. In 2008, it was time to renegotiate the contract.

135. On January 17, 2008, the AOM submitted a proposed Memorandum of Agreement that included new parental leave, locum program, benefits, operational fee and compensation increases. [134]

136. On February 12, 2008, I wrote to Wendy Katherine, requesting to begin reviewing the current funding agreement. [135]

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131 Funding Agreement Proposals from AOM to MOH (October 2008) AOM0000686.

132 Letter from Premier G. Smitherman to E. Johnson re: Investments in Midwifery (July 25, 2007) AOM0001794.

133 Letter from Elana Johnson, President, AOM to John McKinley, ADM, Health System Information Management Division (September 6, 2007) AOM0010308.

134 Proposed Memorandum of Agreement between AOM and OMP (January 17, 2008) AOM0001426.

135 Letter from Elana Johnson to Wendy Katherine, OMP re: Beginning Reviewing the Funding Agreement (February 12, 2008) MOH000428.

137. On February 21, 2008, Wendy Katherine responded, requesting that we forward our "list of priorities" for negotiations and stating that she would contact us to set up a preliminary discussion when it was received.[136]

138. We forwarded these priorities in a letter I wrote dated April 30, 2008. The letter had the subject heading: "Creating Equity for Midwives in Ontario's Health Care System."[137] This letter was presented at the first negotiations meeting on April 30 2008, attended by Kilroy, Berinstein, Stadelbauer, Alice Ormiston and I for the AOM, with Wendy Katherine, Samantha Ball, Joan Mongeon and Rena Porteous from the OMP.

139. My April 30, 2008 letter:

(a) identified substantial compensation increases as a key priority;

(b) stated that "In order the have a parallel processes to physicians and nurses, and to place midwives on an equal professional plane as these health care professionals, the AOM is seeking a dispute resolution process to deal with disagreements that arise in the interpretation of the Funding Agreement, including clarification of those conditions that will allow the withholding of payments by a TPA"

(c) asks for "renegotiation commitment: commitment to review funding agreement no later than Dec 1 2010

(d) identified the need for midwives to get equitable treatment with other health care professionals with respect to such issues as professional development, maternity and parental leave, and rural and remote practice provisions. The AOM sought recognition as the official negotiation partner and an obligation to not change the funding agreement or midwifery workload in between contracts.

140. In May, 2008, Katrina Kilroy took over as the AOM President and continued in that position until May, 2012. However, I continued to be involved in the negotiations as well as AOM Executive Director, Kelly Stadelbauer, and Juana Berinstein.

141. In advance of the negotiations, we provided this list of issues and proposals to the OMP, including a request for an increase in compensation.[138]

136 Letter from W. Katherine to E. Johnson re negotiations (February 21, 2008) AOM0001464.

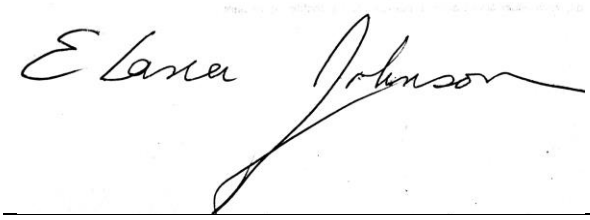
137 Letter dated April 30, 2008 from Elana Johnson, President of the Association of Ontario Midwives to Wendy Katherine, Coordinator of Ontario Midwifery Program (April 30, 2008) AOM0000685.

138 Draft AOM Catalogue of Issues and Proposal Submitted to OMP (2008) AOM0002586.

142. I was still involved in negotiations through to March 2009 after Katrina Kilroy had assumed the Presidency. [139] [140] [141] [142]

SWORN this 27th day of July 2016.

A Commissioner for taking Affidavits



Elana Johnson

139 See: Emails between Elana Johnson and Katrina Kilroy re. negotiations, copying K Stadelbauer and N Patton, (January 19, 2009), AOM0001269.

140 Various Emails Between E. Johnson, K. Kilroy, N. Patton re: Phone Campaign to MPPs, (January 19, 2009), AOM0006112.

141 Email from N. Patton to E. Johnson, K. Stadelbauer, K. Kilroy forwarding Email from Deb Matthews to E. Johnson dated February 2, 2009 re: Acknowledging Issues of Midwives, (February 2, 2009), AOM0006138.

142 Emails between K. Stadelbauer and J. Hendry (MOH) dated March 5 and March 6, 2009 re. MOU. Rena Porteous, Samantha Ball (MOH), Joan Mongeon (MOH), K. Kilroy, E. Johnson, Neil Patton, Alisa Simon and Alice Ormiston copied on emails. (March 6, 2009), AOM0001555.