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 BRIDGET LYNCH

I, Bridget Lynch, of the City of Toronto, 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 33 years. I was President of the Association of Ontario Midwives (AOM) from 1997 to 2001 and President of the International Confederation of Midwives (ICM) from 2008 to 2011. 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 Bridget Lynch (September 17, 2015) AOM0016605.

I. BACKGROUND

1. Education, Apprenticeships and Training

3. I have completed my apprenticeship in midwifery in Toronto in 1985 and I went on to receive a Bachelor of Arts from Norwich University in 1998. In 2005 I completed my Master's degree in Women's Studies at York University.

4. I underwent an extensive apprenticeship in midwifery from 1983 to 1985 as there were no formal midwifery education programs in Toronto at that time. I apprenticed with midwives Mary Sharpe and Catherine Ruskin, two of the busiest working midwives at that time in the province of Ontario. During that 2 year period I attended antenatal, intrapartum and postpartum care for more than 80 clients, all planning home births.

5. Prior to the apprenticeship I had completed a one year course to become a childbirth educator (1979 to 1980) run by the International Childbirth Education Association (ICEA) and I taught prenatal classes for that organization from 1981 to 1985, teaching more than 1000 couples. I attended many births in hospital as a labour support person, attending in all the hospitals in downtown Toronto.

6. In 1993 I graduated from the Michener Institute of Applied Health Sciences Midwifery Program.

7. I am also certified as an ALARM instructor by the Society of Obstetricians and Gynecologists of Canada (SOGC). I have been an Emergency Skills Instructor for the AOM for more than 15 years.

2. Practicing Midwife

8. In 1985, I started practising as a midwife following a two year apprenticeship and was among the first midwives to be registered in the province in January 1994.

9. Since 1994, I have provided midwifery services with Community Midwives of Toronto (CMT) of which I am a founding and managing partner. The practice now has 6 managing partners, 3 associate partners and a rotating position for a New Registrant midwife. The practice midwives have privileges at St. Michael's Hospital.

10. I have held leadership roles in hospitals, including as the Head Midwife at St Michael's Hospital (2005 – 2010), the first Head Midwife at Women's College Hospital (1996 - 1998) and the first Head Midwife at Wellesley Hospital (1994-1996).

3. Academic and Clinical Teaching

11. I have been an Assistant Professor in the Midwifery Education Program in the Department of Family Medicine at McMaster University since 200. I have taught across the spectrum of the 4 year program, including both academic and clinical courses.

12. I was the Interim Education Director in the Multi-Jurisdictional Midwifery Bridging Program from 2012 – 2013, a joint bridging program administered through the Ministries of Health in British Columbia, Alberta, Manitoba and Saskatchewan.

13. I have experience in the development, delivery and evaluation of midwifery educational programmes including being co-developer of the McMaster Midwifery Global Health Pre-Departure Modules. These modules were developed to prepare midwifery students for month long placements in foreign jurisdictions, particularly in low-resource countries. They highlighted the cultural and public health issues that our students would be facing and how to navigate them with cultural sensitivity.

14. In 2012, I developed a 3 year curriculum for a new midwifery education program developed by BRAC, a Bangladesh NGO that provides healthcare and education to serve the poorer communities of Bangladesh. The program is being run in 6 sites across the country.

15. As well, I have been a clinical preceptor in the Midwifery Education Program since 1995.

4. AOM/CAM/ICM

16. I was a founding member of the AOM prior to regulation. I was elected to the AOM Board in 1996 and served as the President of the AOM from 1997 to May 2001. This was during the period of devolution, the negotiation of the new

devolution course of care fees contract and the requests for fair and equitable compensation. I was an active member of the AOM's Midwifery Compensation Task Force starting in 2000.

17. I also was a founding board member of the Canadian Association of Midwives (CAM). My work with the political side of midwifery led me to seek nomination for and be the first Canadian midwife elected to the Board of the International Confederation of Midwives as a Regional Representative of the Americas Region in 2002. I was subsequently elected Vice President from 2005 to 2008 and President from 2008 to 2011.

5. International Midwifery and Maternal and Newborn Health

18. As President of the ICM I initiated and led the organization to develop global standards for the education and regulation of midwives in all countries. These global standards are the first such standards for any health profession in the world and have been agreed by the World Health Organization (WHO), the International Federation of Obstetricians and Gynecologists (FIGO) and the International Pediatric Society (IPS). They are being used by governments around the world to develop and/or upgrade the profession and practice of midwifery.

19. I was the first midwife in Canada to be made an Honorary Fellow of the of the Society of Obstetricians and Gynecologists of Canada (SOGC) in recognition of the contributions I have made to midwifery and maternal and newborn health at the global level.

20. I have been an invited speaker at meetings and conferences in more than 40 countries globally to speak about midwifery education, regulation and the role of midwives in maternal and newborn health in health systems globally. My presentations have focussed on the general invisibility of and lack of respect for midwifery as a profession, while also identifying midwifery as central to the improvement of maternal and newborn health globally.

21. As well, I have met with Ministers of Health in various countries including Afghanistan, Bangladesh, Ethiopia, Turkey and Haiti to discuss the role and development of midwifery in their respective health care systems. In my ICM role, I have represented midwifery in international symposia in Africa, Asia, South Pacific, Latin America and the Caribbean. I continue to be invited currently as a speaker at national and international conferences to discuss the role of midwifery, including strengthening the profession and its appropriate positioning in health care systems and in relationship to nursing and obstetrics

22. I led an international symposium that reviewed the role of midwives as foundational to maternal and newborn healthcare globally, leading to the first

publication of a State of the World Midwives Report[2] of which I am a contributing author, and the development of the recent Lancet Journal Series on Midwifery (June 2014) (which can be viewed at: http://www.thelancet.com/series/midwifery)

23. I was appointed as a board member to represent midwifery on the Partnership for Maternal Newborn and Child Health (PMNCH) from 2007-2011. This global Partnership, headquartered at the World Health Organization in Geneva, joins the reproductive, maternal, newborn and child health (RMNCH) communities into an alliance of more than 680 member organizations, across seven constituencies: academic, research and teaching institutions; donors and foundations; health-care professionals associations; multilateral organizations; non-governmental organizations; partner countries; and the private sector. The PMNCH is the global body tasked with addressing Goals 5 and 6 of the Millennium Development Goals (2000-2015),and is the targets related to RMNCH in the newly launched Sustainable Development Goals (2015-2030).

6. Publications and Presentations

24. I have written extensively on midwifery, with respect to practice issues, inter professional collaboration, strengthening education and regulation and more generally in relation to the building of sustainable midwifery services globally. These include the 2005 Journal article, "Midwifery in the 21st Century: The Politics of Economies, Medicine and Health"[3] and the 2014 Journal article I co-authored: "Delivering Services and Influencing Policy: Health Care Professionals Join Forces to Improve Maternal, Newborn and Child Health."[4]

7. Inter Professional Collaboration

25. As highlighted above, my professional career has involved extensive inter professional collaboration with maternal and newborn health professionals including physicians and nurse practitioners. This includes:

(a) my long term work as a Head Midwife in three Toronto area hospitals;

(b) my work at the global level working with the international societies of obstetrics, pediatrics and nursing with other partners to advance maternal, newborn and child health; and

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2 *The State of the World's Midwifery: A Universal Pathway - A Women's Right to Health.* United Nations Population Fund (UNFPA) (2014) AOM0017372.

3 Midwifery in the 21st Century: The Politics of Economies, Medicine and Health (2005) AOM0017414.

4 Delivering Services and Influencing Policy: Health Care Professionals Join Forces to Improve Maternal, Newborn and Child Health (2014) AOM0017413.

(c) my work in Ontario for the AOM and also my 3 year participation in a joint McMaster University/University of Haiti inter professional project, including obstetricians, nurses, midwives and pediatricians.

II. EXPERIENCES OF STEREOTYPING, PREJUDICES AND HOSTILITY

1. Introduction

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

2. How I came to Midwifery

27. I came to midwifery because of my own experiences with childbirth. My first child was born in 1974 in an Ottawa hospital with an obstetrician I did not know. Despite my desire to have a natural birth, I was not supported in that choice in the hospital setting and ended up having an epidural, episiotomy and forceps delivery in the context of a straightforward, risk free delivery. I only had 10 minutes with my baby girl when she was taken away for the night and I was told I could see her in the morning. I cried all night in fury that my healthy daughter was being removed from me by strangers and I vowed to never let it happen again. I vowed to have my next baby at home as I knew there were “hippies” in California who were having babies at home. Three months later, I was pregnant again and called all the obstetricians in the yellow pages in Ottawa to see if they would attend at delivery at home. They thought I was “crazy” and they declined. Finally at 8 months pregnant, I found a new family physician in town who would attend.

28. I moved to Toronto and found another family physician to attend at home with my third baby. Subsequently, I became concerned that my two daughters would not have the choices I had managed to get so I became a Childbirth Educator and published a monthly newspaper with local birth advocates, called “Choices in Childbirth" which was distributed in family doctors’ offices and health food stores with a distribution of 10,000. Couples started asking me to attend them as a labour support person in their planned hospital births. Soon thereafter midwife Catherine Ruskin (formerly Penz) asked me to attend with her and local family doctors who were attending home births. When family physicians had to stop attending home births in 1983 due to a directive by the College of Physicians and Surgeons, I started my apprenticeship with midwives Catherine Ruskin and Mary Sharpe.

3. Pre-Regulation

29. I faced many challenges at this time, much of which is described in Vicki Van Wagner’s 1991 thesis, With Women: Community Midwifery in Ontario.

30. For example, the first time I called 911 at a home birth to get an ambulance in 1983 during my apprenticeship, we were afraid we might be arrested for

practising medicine without a licence which had been happening in many states in the United States at that time. During the ensuing years, every time we accompanied a woman into a hospital either as home birth transport or as labour support for a planned hospital birth we had to deal with patriarchal and patronizing, if not outright hostile, obstetricians. It taught me to be grateful for the little gestures of acceptance, to keep my mouth shut and to not rock the boat. What sustained us was our commitment to our clients and their experiences of child birth. We were passionate about reclaiming the birth experience for women. We were able to survive this period because there were a handful of physicians who supported our work who were primarily family physicians with whom we worked.

31. There was also hostility and lack of understanding of our work on the part of nursing staff who often resented our presence and often acted hostile to us as they told us we were undermining their work.

32. The stereotypes and prejudices we faced made me anxious each time I entered a hospital setting with a woman in labour. It was emotionally exhausting and often humiliating when I experienced my work being devalued.

4. Post-Regulation.

33. Stereotypes and prejudices continued post-regulation, even in my role as Head Midwife in all three hospital settings. I was constantly explaining and defending the *Midwifery Act* and our College of Midwives of Ontario approved standards of practice with obstetricians who frequently refused to accept them and challenged the clear evidence that these standards were based on. The vast majority of obstetricians I dealt with continued to regard home births as not only unsafe but an irresponsible choice. There was an ongoing suspicion that midwives were telling women to give birth at home, and a reluctance on the part of obstetricians to put women at the centre of care. For several decades the notion of providing women with information and respecting their informed decisions was disregarded by many obstetricians and nursing as an ‘excuse’ for the care I was providing.

34. Not only did I experience this conduct at the local hospital level, but I also experienced it in my capacity as AOM President.

35. For example, during my term as AOM President, Dr. R. Reid, the President of the Society of Obstetricians and Gynaecologists for Canada wrote a policy statement regarding midwifery in 1998 during my term as President. The policy statement endorsed midwifery, but opposed home births "because of the potential risks to mother and fetus." I wrote back to him, advising him that home births are "an essential aspect of a midwife's regulated scope of practice in Ontario" and that the statement provides "no research based evidence that midwife attended home

birth is not an equivalent alternative to hospital birth for low risk women."[5] Post regulation, this led to considerable barriers for midwives integrating in hospitals. The media contributed to this debate. [6]

5. Hospital Integration barriers

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

37. There is one notable exception. At the Wellesley Hospital we had an extraordinary experience of acceptance by the Chief of Obstetrics, Dr. Paul McCleary back in 1994. He welcomed the new midwifery staff to the Wellesley with an announcement in the Toronto Star with colour photographs of all 8 of us. When the Wellesley closed and the hospital staff were transferred to St. Michael's Hospital in 1998. Unlike the welcome we received at the Wellesley, the integration process was long, slow and painful. Lacking supportive leadership to integrate us, we were often subjected to dismissive conduct by the obstetricians for many years.

III. 1994-1997: INITIAL DEVOLUTION DISCUSSIONS

1. Introduction

38. I was President of the AOM during the devolution negotiations with the Community Health Branch (CHB) of the Ministry of Health In the late 1990s. The primary driver of those negotiations was the desire by the Ministry to ensure that midwives could not be considered as employees of either the Ministry or local transfer payment agencies with whom midwifery practice groups would have a funding contract.

39. At the request of the Ministry, the AOM developed a new relationship contract based on independent contractor status. I was also involved in making requests to the Ministry for equitable compensation, including cost of living increases, during the period of my Presidency.

40. In the fall of, 1997, I became Interim AOM President until May of 1998 when I was elected President and continued in that role until May, 2001. Following my election as President in May 1998, I initiated a consultation process to fundamentally change how the AOM was organized and interfaced with the membership.

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5 Letter to Dr. R. Reid, President, Society of Obstetricians and Gynaecologists of Canada from AOM President Bridget Lynch re: SOGC's Policy Statement: Midwifery (February 27, 1998) AOM0002060.

6 Toronto Star Article, "Controversy Lingers Over Role of Midwife" (1998-06-29) AOM0015525.

41. During my term the AOM became a membership driven organization, wherein the members set the goals and the Board was tasked with developing a strategic plan and implementing them. This process included having focus groups and surveying midwives across the province to establish the priorities for the organization. We also developed a new vision and mission statement for the organization. This process was undertaken while I also devoted virtually my entire term as AOM President working on the devolution process.

42. When I became Interim President in 1997, I observed that the relationship between the AOM and the Community Health Branch was filled with a sense of mutual distrust. As the Interim President, I sought to establish a positive working relationship between the AOM and the all levels at the Ministry of Health. I felt that a positive relationship between the AOM and the Ministry was critical to ensuring high quality midwifery services to Ontario women and birthing parents.

2. Efforts to Devolve by December 31, 1997

43. When midwifery became regulated in 1994, the Lebel Midwifery Care Organization (LMCO) was created to act as an interim central body through which funds would be transferred from the Ministry to midwifery practice groups (MPGs). The September 1993 Ontario Midwifery Program Framework provided for this transition.[7] However, the plan was that this role would ultimately be transferred to multiple transfer payment agencies across the province The LMCO's mandate expired December 31, 1997.

44. Prior to my becoming Interim President, during the period from 1994 – 1997, the AOM and the Ministry had discussions about the issue of devolution, but such discussions were subsequently suspended. The AOM and Ministry were unable to resolve the issue of the employment status of midwives and had been unable to get changes to the *Employment Standards Act* to provide an exemption for midwifery care from the hours of work and other provisions.[8]

45. They were also unable to agree on the appropriate criteria for devolving to local transfer payment agencies. The CHB had hired ARA Consulting to produce a report on the criteria for transfer payment agencies.[9]

46. With the 1997 deadline approaching, the LMCO obtained a legal opinion from the Filion Wakley law firm that the midwives were likely best categorized under the current funding and management structure as LMCO employees and not as

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7 Ontario Midwifery Program Framework Developed by the Midwifery Funding Working Group, September, 1993 (September 1993) AOM0007064 at p 5.

8 get cite to document to support this.AOM Funding Committee Report (1996/02/15) AOM0006319 at p 2.

9 Cite to ARA report Review of Criteria for Midwifery Program Transfer Payment Agencies, July 1997 AOM0001117.

independent contractors and therefore would fall under employee legal protections (which included the *Pay Equity Act*).[10]

3. AOM Survey on Devolution

47. The AOM took steps to seek input from the membership on devolution in 1996 at the regional meetings throughout the fall.[11] In August and September, 1996, Eileen Hutton and Remi Ejiwunmi conducted a survey of all the Midwifery Practice Groups. The summary of findings from midwifery practice groups yielded that 95% of those surveyed disagreed with exploring employer-employee relationships with the identified TPAs and 91% agreed with maintaining a contract relationship with the LMCO,[12] in order to protect the model of care and meet the desired needs of the women of Ontario.

4. AOM Consensus Building Session on Devolution in October 1996

48. Following the survey, the AOM held a consensus building session on October 24, 1996. The purpose of this session was to relay information to members from the survey and other background information on the devolution process and to obtain broad consultation from members regarding the next steps.[13] This resulted in a November, 1996 Draft Report on Consensus Building Session on Devolution, which reinforced midwives' commitment to avoiding an employee model.

IV. HIATUS FROM DEVOLUTION NEGOTIATIONS

49. By May 1997 it had become clear that the Ministry was committed to avoiding an employee model. Notes from that time show that the Ministry was originally concerned about the LMCO being seen to be an employer, and the Ministry recommended that a second option of contractor status be available. The Ministry did not desire employer status for the LMCO because then employer obligations (e.g. employer deductions and ESA standards) would apply.[14]

50. In the August, 1997 paper, Towards More Integrated Cost Effective Midwifery Care in Ontario, the AOM made our concerns about the lack of midwifery consultation explicit, writing that "the AOM has had little formal input into devolution specifically. This has led to a real, legitimate concern among

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10 Letter to LMCO Hal Delair from Filion Wakely re: Employer and Director and Officers Obligations and Liabilities Opinion. (January 10, 1997) AOM0012609.

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

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

13 1996 Draft Report on Consensus Building Session on Devolution (November, 1996) AOM0002841.

14 Minutes of Midwifery Liaison Committee Meeting (May 6, 1997) AOM0010252.

practicing midwives as to their future status." We proposed new policy goals for developing a devolution process which would address 8 key issues:

- a new program consultation mechanism (a provincial midwifery committee with representatives from the AOM, OMCN and the Ministry);
- alternative funding approach for TPAs (discussed below);
- financial accountability (by maintaining a provincial funding agreement and financial accountability procedures);
- protecting the model of midwifery care (through the CMO and through Midwifery Practice Groups where midwives would have a non-employee status allowing them to provide 24 hour on-call service);
- preserved and enhanced consumer partnerships (continued consultation with the OMCN, including a seat on the propose Provincial Midwifery Committee);
- evidence-based policies (the proposed Provincial Midwifery Committee would ensure that evidence-based policies and practices are incorporated into midwifery);
- supporting midwifery practice groups (by funding the AOM to hire staff to assist Practice Groups with managing business aspects of the practice) and;
- clear roles and responsibilities (including the proposed Provincial Midwifery Committee).[15]

51. While the AOM initially preferred in these discussions to continue with the "dependent contractor" status with an exemption under the *Employment Standards Act* (*ESA)*, we were persuaded by the Ministry that the change to independent contracts was necessary to preserve our model of care, since the Ministry of Labour did not appear willing to implement the necessary exemptions into the *ESA*. The *Employment Standards Act, 2000,* which was the first overhaul of the *Act* in many years, did not contain any such exemptions.

52. As a result, the AOM Board, with the support of our legal counsel, agreed to create a new relationship contract in the form of a new funding agreement with the CHB that was consistent with the midwifery model of care and preserved accessibility of midwifery to Ontario women.

15 See Report by AOM re: Towards More Integrated, Cost-Effective Midwifery in Ontario (1997-01-01 est) AOM0002361 at p. 6.

V. THE RESUMPTION OF DEVOLUTION DISCUSSIONS – 1997-2000

1. Introduction

53. As of September 1997 the issue of whether midwives would be interpreted as employees or contractors remained unresolved.[16] We were told that the legal staff at the Ministry were drafting a contract for midwives which was intended to be a translation of the funding agreement to take effect between the Ministry and any TPA as well as between the TPA and a MPG after devolution.

54. On September 16 1997, the MOH Assistant Deputy Minister, Ron Sapsford, replied to President Cameron.[17] Sapsford took the position that midwives would work as employees and that, "the ministry expects that midwives will be able to practice the Ontario model of midwifery care as employees once the necessary regulation changes to the Employment Standard Act have been made". He further stated that direct negotiations with the AOM are inconsistent with a managed program and that the the Community Health Branch, with its experience with the network of [CHC's]… is well situated within the ministry to manage the Midwifery Program at this time."

55. On September 19, 1997 the AOM Board agreed to remove the halt to devolution on the understanding that the contract being drafted would allow midwives to be autonomous and protect our model of care.[18] While we had originally wanted an dependent contractor and not employee model, discussions with the Ministry had convinced us that without ESA exemptions, it appeared that an independent contractor model would be necessary to protect the model of care.

56. As Carol Cameron was to go on maternity leave in November of 1997, I was asked by the Board to become Interim President until the end of her elected term.[19]

2. Consultation with the Ministry

57. Our first consultation session with the Community Health Branch took place on October 17, 1997. The meeting focused on the issue of appropriate roles for midwifery practice groups and transfer payment agencies post devolution.[20] AOM

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

17 Letter from MOH ADM Ron Sapsford, Institutional Health and Community Services to AOM President Carol Cameron Ministry Responding to AOM's Towards More Integrated Cost Effective Midwifery Care in Ontario. (September 16, 1997) AOM0011364.

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

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

20 Memo from AOM Executive to MPGs re: Devolution Update (October 8, 1997) AOM0003742.

Vice President Ejiwunmi and I met weekly with Hal De Lair (LMCO) and Bonnie Health (Director of the Ontario Midwifery Program (OMP) in the CHB).[21] At these meetings it became clear that the Ministry was in fact drafting a new contract and not just "translating" the original funding agreement as we had initially understood the process. We were concerned by the absence of consultation with midwives regarding this new funding agreement.[22]

3. AOM Devolution Strategy Team

58. In November of 1997, the AOM's Board of Directors struck the Devolution Strategy Team (DST), which included myself, AOM Regional Representatives, Remi Ejiwunmi, Bobbi Soderstrom and Wendy Katherine as the AOM's Director of Professional Issues. On December 5, 1997, the DST drafted and circulated a discussion paper to be read by members in advance of the meetings and a series of key issues to be discussed.[23] A major focus of these meetings was to determine:

> *…whether one TPA should flow funds to all midwifery practices within a local area; whether individual practices within an area should engage in separate funding relationships with local TPAs (in 'one-on-one' relationships); or whether both approaches should be pursued, depending on the local situation.*

59. On December 6, 1997, the AOM circulated a second memorandum that addressed the contractual status of midwives in the context of devolution.[24] The memorandum mentions that TPAs may want to explore employment model, but the AOM asserts that the contractual model is necessary to protect model of care and that MPGs should not make independent contracts with the TPAs, because this could jeopardize the process of a consistent provincial bargaining process, ensuring similar treatment across the province.

60. In the week of December 7, 1997, the Regional Representatives and the DST facilitated meetings with the midwives of their region to discuss Devolution and to get feedback from midwives on their visions for and concerns about the process.

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21 Minutes from AOM Board Retreat (1997/11/03) AOM0004174.

22 Minutes from AOM Board Retreat (1997/11/03) AOM0004174.

23 Report by AOM for AOM Regional Reps re: Devolution Strategy Team's Summary for Regional Representatives (December 5, 1997) AOM0001119.

24 AOM Communication to Members; Docs re employment / contractor relationship; Funding of professions; Regarding Midwives (December 6, 1997) AOM0001118.

4. Late 1997 Discussions with MOHLTC and LMCO

61. On November 28, 1997, Wendy Katherine and I met with the other members of the "Midwifery Liaison Committee," namely Laurie Zagar from the OMCN, Robin Kilpatrick from the CMO, Vicki Van Wagner representing the Midwifery Education Program, Bonnie Heath from the OMP, and Hal De Lair from the LMCO.[25] In that meeting, we discussed the AOM's concern that some MPGs might be funded locally while others remain funded centrally. The conversation assured us that given the approval process for the contract between the TPAs and the MPGs, the transfer of funding would likely happen all at once, on April 1, 1998.

62. On December 9, 1997 the AOM Board and Staff met with the Assistant Deputy Minister of the Ministry of Health, Ron Sapsford, to discuss resuming a devolution process, contract issues, and an improved method of consultation between the Ministry and the AOM. I was optimistic at that time that relations would improve with the Ministry.

5. 1998 Meetings with Ministry

63. By early 1998, the AOM drafted another memorandum for members that confirmed that the new contract format was to be consistent with independent contractor model, rather than the prior model which more closely resembled employee/employer model.[26] This was a requirement set by the Ministry, but the AOM supported it, in order to preserve the quality and model of care for our clients and an autonomy of practice for the midwives.

64. During the period 1998-1999, the discussions between the AOM and the CHB were consumed with the Ministry mandate to devolve from the central LMCO to local transfer payment agencies (TPAs) and the Ministry directive to create an “independent contractor” and not "employee" relationship.

65. We had supported the autonomy of practice which had been originally agreed by the Government and the AOM. The membership wanted to ensure that in any move to an independent contractor status that we not lose any compensation or other funding entitlements that had existed to date, including benefits, caseload variables, travel, grants and administrative costs.

66. On January 7, 1998, AOM representatives (Remi Ejiwunmi, Wendy Katherine, Bobbi Soderstrom,) and I met with the Ministry designated potential TPA representatives to discuss devolution. All practice groups had been assigned by the OMP to be devolved to one of these TPAs. At that meeting we discussed a

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25 Memo from Hal De Lair, LMCO, to LMCO Board re: December 13 Report from the Executive Director (December 11, 1997) AOM0013323.

26 AOM Introduction for Members to the MOH Contract for Midwives (1998-01-01) AOM0001296.

number of important issues, including insurance, ownership of assets, catchment areas and referrals, among others.[27]

67. On January 20, 1998, the OMP's Director, Bonnie Heath, sent me a copy of a draft of the agreement that would allow TPAs to contract with MPGs but said the Ministry is "not prepared to enter into formal negotiations with the AOM concerning the terms of this agreement but we are interested in consulting with your organization as the representative of the midwifery profession". We were invited by that letter to a meeting on January 29, 1998 as a consultation meeting.[28]

68. On January 22, 1998, to prepare for the January 29, 1998 meeting, the DST met to discuss the OMP's proposed contract and the process of devolution. We felt that the structure of the TPA agreement was generally appropriate, but there were significant gaps and issues identified, including the risk of losing funding for expenses and insurance and the risk of MPGs not being funded equitably across the province. We had concerns about the definition of catchment areas, the lack of detail describing the growth of practices, and the responsibility of the TPA to ensure midwifery involvement on Boards of Directors of the local TPAs. We went through the agreement and discussed it clause by clause as reflected in the notes of the meeting.[29]

69. On January 29, 1998, the AOM (Remi Ejiwunmi, Wendy Katherine, Bobbi Soderstrom, myself and our legal counsel, Jean Teillet) and the OMPs' Bonnie Heath and legal counsel for the Ministry, Sari Teitlebaum, had our first contract negotiation session concerning the devolution issues and new contract. Despite what Bonnie Heath said in her letter about not negotiating, the meetings were definitely negotiations. Both parties, including our respective legal counsels, discussed and put forward proposals and counter proposals which were discussed, considered and agreed.

70. The Ministry proposed a course of care compensation structure in this meeting. Prior to this time, the MPGs received 1/12 of their global compensation every month which had been characterized as a "salary".[30] While the Ministry wanted midwives to be independent contractors under the new model, they were still moving ahead with attempting to get midwives some exemptions under the *ESA*,

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27 Agenda for Meeting between AOM and TPA Representatives (January 7, 1998) AOM0001981.

28 Letter from OMP Bonnie Heath to AOM Bridget Lynch re: draft funding agreement (January 20, 1998) AOM0001982.

29 Notes from AOM Devolution Strategy Group Meeting re: Contract & Devolution and with comments on MOH draft contract and comparison to existing funding agreement (January 22, 1998) AOM0001294.

30 Meeting Notes of Contract Consultation Session between AOM and MOH (January 29, 1998) AOM0001976.

as a part of the ESA overhaul that the Ministry of Labour had planned to undertake beginning in March of that year.

71. On January 31, 1998, Hal DeLair, the LMCO Executive Director, published a memorandum identifying that the LMCO was preparing a final report as their operations were coming to an end. [31]

72. In February of 1998, I wrote to DeLair, requesting that detailed information be included in the LMCO's final report, including the LMCO Operational guidelines, LMCO data that had been collected since 1994, and insights about what areas of the Midwifery Program management should rest with the Ministry.[32]

6. Further AOM Communications and Focus

73. On February 2, 1998, the AOM Executive sent a memorandum to all the MPGs, explaining the process up to that point in the negotiation of the new contract and that further meetings had been scheduled. We were working on translating the LMCO practices into the new structure. We noted that the contract's primary goal was to define midwives as independent contractors and that the fundamental principles of the OMP continued to be priorities for the Ministry. [33]

74. By mid-February, the AOM's DST decided to focus on developing an AOM platform for our desired funding mechanism within the contract model. [34]

75. On February 19, 1998, I met with CMO and MEP representatives to discuss developing a Midwifery Coordinating Body of AOM/CMO/MEP as a consultative body to the OMP. The issues of midwife privileges at hospitals, health human resource planning, financial policies not covered in the contract, and policies to deal with caseload variables, second attendants, and solo practices were all issues that affected the four organizations.[35]

7. Independent Contractor Status

76. The AOM met again for contract negotiations on February 23, 1998 and February 26, 1998. During the February 23, 1998 meeting, the AOM presented a proposal to be paid according to a virtually identical mechanism that we had had in place since 1994. The Ministry had proposed that we be paid only at the end of a course of care, generally that meant a full ten months after our care and work

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31 Memorandum dated January 31, 1998 from Hal DeLair, the LMCO Executive Director. AOM0004195.

32 Letter from B. Lynch to H. De Lair re: Final Report (February, 1998) AOM0004105.

33 Letter from AOM Executive to MPGs re: Devolution Update (February 2, 1998) AOM0004243.

34 1998/02/04 Memo from AOM Wendy Katherine to AOM Devolution Strategy Team re funding policies (February 4, 1998) AOM0001293.

35 Agenda, Re: AOM/CMO/MEP Meeting re: Midwifery Coordinating Body AOM0014259.

with clients began. The Ministry continued to insist that compensation be paid in arrears in order to be considered an independent contractor.

77. On March 2, 1998, I wrote to ADM Ron Sapsford concerning the importance of a developing a multi-stakeholder group as a planning and advisory group to the OMP. Such a mechanism would allow stakeholders to have a meaningful input into the planning and overall development of the OMP.[36]

78. On March 3, 1998 at a meeting of the DST, members remained concerned about the income instability payment in arrears would cause the midwifery practices. [37] There was also an ongoing concern that the particular needs of rural and remote midwives needed to be addressed in the new funding agreement. [38]

79. On March 12, 1998, the MOH produced a further draft of the TPA-MPG funding agreement[39], along with an explanatory memorandum.[40] The memorandum clearly states that:

> *The Primary principle guiding the translation of the Ontario Midwifery Program Funding Agreement into a contract format, has been the desire, of the Ministry of Health, to clearly define midwives as independent contractors. It has been the opinion of the Ministry of Health that the LMCO funding agreement describes a relationship between transfer payment agencies and midwifery practice groups that too closely resembles that of employer and employee. In drafting the new contract agreement, the Ministry has focused on meeting the many legal requirements for creating an independent contractor agreement between midwifery practices and TPAs. The ministry has removed many of the aspects of the LMCO funding agreement, which their legal counsel interpreted as being indicative of an employer-employee agreement. One of the difficulties of creating this new contract is that there are many criteria upon which the courts and the government could interpret a contract to be representative of an independent contractor versus a dependent contractor or an employee. The new contract must be as clear as possible about the independent contractor relationship.*

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36 Letter dated March 2, 1998, from AOM President Brigid Lynch to ADM Ron Sapsford AOM0001985.

37 Letter from OMP Bonnie Heath to AOM Bridget Lynch re: draft funding agreement (January 20, 1998) AOM0004214.

38 Memo from W. Katherine to AOM Members re: Contract and Budgets post-LMCO (March 3, 1998) AOM0004214.

39 Draft for discussion funding agreement between MOH and TPA (March 12, 1998) AOM0001295.

40 Draft AOM Explanatory Document to Accompany Draft II of Funding Agreement (March 15, 1998) AOM0004136.

80. On March 26, 1998, the AOM's legal counsel. Jean Teillet, submitted to Ministry legal counsel, Sara Teitlebaum, the AOM's outstanding concerns the AOM had with the March 12, 1998 Ministry draft funding agreement.

8. Interim TPA: Lawrence Heights Community Health Centre (LHCHC)

81. In late March, 1998, the LMCO would cease to exist, but the TPAs had not yet been operationalized because of the delays in the creation of the new contract

82. As a result, and to cover an interim timeframe, on March 31, 1998, the Ministry assigned Lawrence Heights Community Health Centre (LHCHC) the Interim Trustee, replacing the LMCO, for all practice groups in the province, This interim period, until the devolution to community TPAs could take place, was expected to last two months. The LMCO ceased to exist as of April 1, 1998.

83. On July 13, 1998, the AOM sent a memorandum to the MPGs explaining the new role of LHCHC. [41]

84. Cathy Paul was the Executive Director of LHCHC and involved in the devolution discussions. During this period, the AOM worked directly with Cathy Paul and the CHB to develop and implement an Interim Funding Agreement based on the new independent contractor relationship.

9. April-July, 1998

85. Following a meeting with Bonnie Heath, OMP Director on April 8, 1998, on April 15, 1998, I wrote a letter to Bonnie requesting that the Ministry respond to the outstanding concerns regarding the funding agreement that the AOM had submitted in late March, well in advance of the May 31 deadline. [42]

86. On April 22, 1998, the AOM DST met to review the implications of the independent contractor status, identifying outstanding issues, including grants, benefits, compensation, caseload variables (a "caseload variable" is payment for the same amount of non-clinical work as the work required in a normal course of care, approximately 48 hours) and year end reconciliation, as well as the greatly increased administrative responsibilities that would be expected of midwives.[43]

87. On June 15, 1998, Bonnie Heath wrote back to me, advising me that the contract agreement was undergoing final revisions, implementing the legal opinion that the Ministry had received from the Management Board Secretariat and would be

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41 Memo from Wendy Katherine (AOM) to all MPGs re: Contract Issues (July 13, 1998) AOM0003745.

42 Letter from Bridget Lynch (AOM) to Bonnie Heath (OMP) re MOH response to AOM comments on contract agreement (April 15, 1998) AOM0014260.

43 AOM Notes re Proposed Funding Model - Independent Contractor (April 22, 1998) AOM0014261.

ready shortly.[44] The substance of the legal opinion was in part to ensure from the Ministry's perspective that the independent contractor status was preserved in the new draft contract agreement.

88. Throughout the negotiations of a new contract agreement in 1997 and early 1998, midwives understood that the government wanted to move to an "independent contractor" relationship, to avoid the TPAs having employer obligations and the contract agreement was being developed with that purpose. However, in June, 1998, upon seeking a second legal opinion, the Ministry decided it needed to make significant changes to the draft contract agreement in order to preserve that independent contractor status.

89. On July 7, 1998, Wendy Katherine forwarded a memorandum updating the AOM team that as a result of the desire to preserve the status of midwives as independent contractors, we had been notified by the Ministry that the draft funding contract agreement, and the funding model itself, had to be significantly revised. Rather than the funds being flowed on a salary and expense budget basis, we had been notified that funds would need to be flowed based on a cost per course of care basis. Midwifery practices would budget and bill for a total number of courses of care and all expenses would come out of the practice's total billings. [45]

90. On July, 13, 1998, the AOM sent a funding update to midwifery practice groups, advising that the Ministry now estimated that there will not be finalized contract until April1, 1999, the beginning of the next fiscal year. The LHCHC was to continue as the Trustee until that time. Our members were very concerned about the delays in budget approvals and other matters during this time. The LHCHC had agreed to help smooth out some of the difficulties during this period.[46] However, we were very concerned that the Ministry's recent legal opinion was going to cause major difficulties for us, particularly as the capitation model of payment might jeopardize our model of care. Midwives were very concerned about planning on to take on clients with later birth dates without an approved budget.

10. Fall, 1998 – Spring, 1999 Funding Negotiations

91. On September 16, 1998, I wrote a letter to Sue Davey, the Acting Director of the OMP requesting that they resume discussions regarding the outstanding issues in the funding agreement contract, in order to facilitate a timely resolution of the

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44 Letter from OMP Co-Ordinator Bonnie Heath to Bridget Lynch, Acting President AOM Re: Revising Funding Contract (June 15, 1998) AOM0001980.

45 Memo from AOM Wendy Katherine to Devolution Strategy Team re Update - Meeting with MOH on July 9, 1998 and contract issues (July 7, 1998) AOM0006514.

46 Memo from Wendy Katherine (AOM) to all MPGs re: Contract Issues (July 13, 1998) AOM0003745.

funding agreement.[47] In this letter I stated that "the AOM feels that this proposed new funding relationship represents a significant departure from the Dependent Contractor relationship, one which could create incentives for profit and gradually erode the midwifery Model of Practice." The letter reminded the Ministry that the dependent contractor relationship was the AOM's preferred payment option.[48] While we had originally favoured an employee relationship, we had come to understand that a contractor relationship would be necessary to protect the autonomy of midwives.

92. On September 16, 1998 I also wrote a letter to ADM Ron Sapsford, advising him that midwives were concerned that such a drastic departure from the "dependent contractor" relationship could "create incentives for profit and gradually erode the midwifery Model of Practice in the Province."[49] I went on to write that:

> *The Board of Directors of the Association of Ontario Midwives would like to notify the Ministry of Health that we believe that a Dependent Contractor relationship is the preferred funding relationship between the midwives of Ontario and transfer payment agencies designated by the MOH. We believe that a Dependent Contractor status best supports both the midwifery Model of Practice and our future relationship with local transfer payment agencies, while recognizing our autonomous regulated professional responsibilities. We would like to work with the Ministry through the CHB to fully explore the Dependent Contractor option, an option which we do not feel has been thoroughly investigated during this last month.*

93. The above-noted letter copied to Sue Davey notified the Ministry that “we believe that a dependent contractor relationship is the preferred funding relationship between the midwives of Ontario and the funding agencies”.

94. The AOM and the CHB continued to have discussions concerning the appropriate terms for the new funding relationship and the contract agreement.

95. During this period, the AOM developed revised Funding Principles to guide the devolution discussions to ensure that they remained harmonized with the new contract relationship. These Principles of Funding were approved November 6, 1998.[50] This document was based on the 1993 *Principles of Funding* document

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47 Letter from AOM President Bridget Lynch to MOH Sue Davey (September 16, 1998) AOM0001979.

48 Letter from AOM President Bridget Lynch to MOHLTC ADM Ron Sapsford re: Dependent Contractor status (1998/09/16) AOM0001978.

49 Letter from Bridget Lynch to Ron Sapsford re: Funding Agreement, copying S. Davy, B. Heath (September 16, 1998) AOM0003775/AOM0001978.

50 AOM Draft Principles of Funding (September 18, 1998) AOM0003786.

and updated by the Devolution Strategy Team, including myself.[51] The Principles, which were provided to the Ministry distinguished remuneration for care from the expenses of running a practice. It also required that "the level of compensation will acknowledge the level of skill and responsibility of midwives as autonomous practitioners." These Principles show that we continued to be concerned with equitable pay that acknowledged the level of skill and responsibility of midwives as autonomous providers, even in the midst of the complex devolution process.

96. On October 8, 1998, I met with CHB representatives, including Sue Davey to discuss the option of midwives retaining dependent contractor status.[52] I believe it was during this meeting that I referred to the fact that there had been no compensation increase since the program started in 1994. Sue Davey indicated that an increase in compensation was not part of this new funding agreement before any discussion could take place.

97. I continued to press Sue Davey to take our outstanding concerns regarding devolution seriously and to meet with us to resolve them. We were still waiting for the Ministry to provide us with the details of their proposed provincial wide funding formula. Midwives were having to cope with the ongoing uncertainty and increasing anxiety over the last year and a half as the process of devolution discussions dragged on and on.

98. By letter dated November 12, 1998, I wrote to Sue Davey referencing a meeting with Bonnie Heath on November 2, 1998.[53] We were particularly concerned that provision needed to be made for the same benefits package and the lack of a schedule describing grants and variables for midwifery work which were equivalent to a course of care. We were still fighting to make sure we did not lose compensation and operational expenses in this process from our original contract. We also wanted formal provincial guidelines to describe the relationship between TPAs and the midwifery practice groups and best serve local communities and needs. We also continued to pursue the development of a provincial planning and advisory committee which we had proposed previously to ADM Sapsford.

In November of 1998, Bonnie Heath left her position as Director of the OMP position. Wendy Pindar became the new Director in early 1999.

99. I also continued to update our members on the status of negotiations, because they were very concerned about the proposed changes to the funding model.[54] By memorandum dated November 11, 1998, the AOM sent to members the

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51 Letter from B. Lynch to Members re: Principles of Funding Document (1998/11/11) AOM0004108.

52 AOM Agenda from Meeting with Community Health Branch (October 8, 1998) AOM0014263.

53 Letter from Bridget Lynch to Sue Davey (November 12, 1998) MOH003924.

54 Letter from B. Lynch to Members re: Principles of Funding Document (November 11, 1998) AOM0004108.

above Principles of Funding document for approval by ballot. The Principles were approved.

100. On November 11, 1996, I distributed these principles to all midwives. I noted that we envisioned the principles as one mechanism to protect the Ontario model of midwifery care. It continued to be clear to all involved that liability insurance payments were an operation expense, separate from compensation.[55]

101. On November 17, 1998 the AOM met again with the CHB, including Sue Davey, to discuss our outstanding concerns regarding devolution and interim planning.[56]

102. On November 18, 1998, Cathy Paul of LHCHC wrote to MPGs to introduce the new block operating fee per FTE and to advise that they were finalizing the 1998-1999 budget. This notification took place 9 months after the fiscal year had started. This was incredibly stressful for the MPGs to have to wait this long to know what their budget and allocated courses of care were for the year. [57]

103. At some point during the fall of 1998, the Community Health Branch transitioned to be known as the Community Health and Promotion Branch (CHPB).

104. On December 11, 1998 the AOM requested MPG budget requests provided by the MPGs to the OMP so that we could analyze them and hear from the MPGs regarding replacing the current budgeting process with the proposed notion of 'block fees' in advance of a meeting with Cathy Paul on December 15, 1998.

11. 1999 Negotiations

105. At a December 15, 1998 meeting, the CHB agreed to immediately share information prepared by LHCHC regarding caseload variables in preparation for the meeting on January 14, 1999 with AOM, CMO, OMP and the Interim Trustee to discuss variables.[58] When their document did not arrive, on January 8, 1999, I wrote to Cathy Paul to again request the document.

106. On January 21, 1999, I wrote again to Cathy Paul regarding the unilateral changing of the definition of "full time equivalent" (40 primary courses of care)

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55 Template letter from LMCO to MPGs re: Budget (1998-11-18) AOM0009945; Letter from Lawrence Heights Community Health Centre (LHCHC) Interim Trustee to Midwives Collective of Toronto setting out new funding structure and process "to streamline the budget process and position the program for the transition to independent contractor status." (1998-11-18) AOM0012872.

56 AOM Agenda from CHB and AOM meeting (November 17, 1998) AOM0014266.

57 Memorandum from Cathy Paul of LHCHC to Midwifery Practice Groups (November 18, 1998) AOM0012872.

58 Letter from AOM Bridget Lynch to LHCHC Cathy Paul (January 8, 1999) AOM0001986.

and the use of block fees to practice groups.[59] This shows that the Ministry did not consult with the AOM on this important issue despite our offer to provide feedback. The AOM outlined in this letter that this block fee potentially jeopardizes various practice groups across the province from continuing to operate.

107. On January 26, 1999, I drafted and sent an AOM Executive memorandum to the membership updating them on the devolution discussions.[60]

108. On January 26, 1999, I met with Kathleen MacMillan, the Provincial Chief Nursing Officer for the Ministry, to discuss the independent contractor model, and the status of midwives under the *ESA*, among other things.[61]

109. On February 4, 1999, I received a letter from Sue Davey that included a revised copy of the funding agreement, that took into account some of the feedback that the AOM had provided to them.[62] Once again, however, we found that liability insurance is described by Ministry as a disbursement.

110. In February of 1999, the AOM began to meet with the Lawrence Heights Community Health Centre Interim TPA Trustee, Cathy Paul, concerning the development of the funding agreement. On February 10, 1999, we met with Cathy Paul to discuss budgetary issues, the evaluation of cost per course of care for rural and solo practicing midwives, as well as the role of the LHCHC during the rest of the devolution process. [63]

111. On February 19, 1999, I wrote a letter to Sue Davey in response to her letter dated February 4, 1999 explaining that due to the many changes that had been made in the most recent draft of the funding agreement that the AOM had been sent, and due to difficulties with scheduling a meeting with our lawyer, I would not be able to provide her with the AOM's feedback on that draft funding agreement before March 5, 1999. We also requested a copy of the funding schedule, which the AOM had not been provided in the most updated version of the agreement.

112. The AOM submitted its final comments to the last draft of the funding agreement to the CHPB on March 5, 1999. [64]

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59 Letter from AOM Bridget Lynch to LHCHC OMP Trustee Cathy Paul re FTE calculation - block fees (January 21, 1998) AOM0001987.

60 AOM Executive communication to members re: Devolution Update (January 26, 1999) AOM0003778.

61 AOM Agenda from Meeting with Kathleen MacMillan (January 26, 1999) AOM0014267.

62 Unsigned Letter from Sue Davey to Bridget Lynch re: revised funding agreement (February 4, 1999) MOH028523.

63 AOM Agenda from Meeting at LHCHC (February 10, 1999) AOM0014269.

64 Urgent Memo to all AOM Members (March 9, 1999) AOM0014276.

113. On March 9, 1999, a memo was sent to all AOM members notifying them that a copy of the funding agreement would be coming on March 15. [65]

114. On March 11, 1999, the AOM executive and funding committee received the funding agreement.

115. On that same day, March 11, 1999 we also received the final version of the "caseload revision" from Cathy Paul. In her note to Wendy Katherine and me, Cathy notes that "the Ministry felt very strongly that [the Practice Development variable] needed to be consistent with the type of support available to other like-funded health providers." This suggests that the Ministry was also looking to comparator health care providers for direction on funding levels and models.[66] In this letter, Cathy further notes that with respect to the non-clinical activities variable, they were not able to support the AOM's proposal for 3 BCCs per midwife to a maximum of 12 per practice, but that this was "more than fair" in the context of the revised fee schedule. I felt that this was another example of midwives having to choose between receiving equitable fees and getting the caseload variables that we require to run a practice.

116. On March 15, 1999 the funding agreement and practice agreement were faxed to all the midwifery practice groups and mailed to all the midwives in the province for them to review.[67]

117. On March 19, 1999, I sent a letter to Wendy Pindar of the CHPB regarding the proposed billing for clients who transfer from one practice group to another during a course of care. Among other things, I advised that the definition of Midwifery Services allowed for a certain amount of flexibility, in the 40 Billable Courses of Care to account for transferring clients. [68]

118. In the week of March 22, 1999, Wendy Katherine and I held regional meetings where I reviewed clause by clause the new proposed funding agreement with members (with about 160 attending). We received many concerns from solo midwives and practice groups concerning the draft funding agreement. These concerns included those from rural MPGs regarding the changes in eligibility for the drive time compensation (CV3) in remote places,[69] the scheduling of payments only in the last month of the fiscal year, [70] and many others.[71] [72] [73] [74] [75] [76]

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65 Memo dated March 9, 1999 to AOM members AOM0014276.

66 Fax from C Paul to AOM Re Caseload (March 11, 1999) AOM0002010.

67 March 15, 1999 version of the Funding Agreement (March 15, 1999) AOM0009860.

68 Memo from AOM Bridget Lynch to OMP Wendy Pinder re" payment for course of care where transfer of client between midwifery practice groups (March 19, 1999,) AOM0002002.

69 Fax from MPG to AOM re CV3 (March 24, 1999) AOM0002079.

70 Fax from MPG re Invoicing (March 24, 1999) AOM0002080.

119. Prompted by all the feedback from the membership, on March 29, 1999, I wrote a letter to Sue Davey expressing my concern that the process was moving ahead without enough opportunity for the membership to provide adequate input and for the AOM to provide appropriate responses to the Ministry.[77] I saw this membership input as being critical to the success of the ratification vote and to ensuring that the membership and the TPAs begin their new relationship positively. I stated that midwives "rightfully expects a process which respects the input of those very midwives who are expected to sign the Agreement."

120. On March 30, 1999 I wrote to Sue Davey again detailing the items that had been raised as concerns by the membership for her response. [78] I also met with Sue Davey on that day about the concerns identified in the letter.

121. On April 1, 1999, Wendy Pindar wrote to me attaching a revised copy of the practice group agreement. In her cover letter, she stated that all of the AOM's input and suggestions had been considered. [79]

122. On April 7, 1999, I wrote to the membership, providing them with the finalized Funding Agreement to vote to ratify it by April 28, 1999.[80]

12. The Funding agreement between the MPGs and the TPAs Effective June 1, 1999

123. After ratification by the midwives, the AOM and the Ministry finalized their agreement concerning the template agreement between the devolved TPAs and the MPGs which was to be effective, June 1, 1999. [81]

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71 Letter to AOM from Womancare re: concerns with 1999 Funding Agreement (March 26, 1999) AOM0002081.

72 Letter to AOM from Brantford on FA (March 26, 1999) AOM0002082.

73 Letter to AOM Bridget Lynch from Kawartha Community Midwives re Concerns with 1999 Funding Agreement (March 26, 1999) AOM0002083.

74 Email from Andrea Patchett, Queen East Midwives to AOM Wendy Katherine re Case Load Variables (March 28, 1999) AOM0002074.

75 Letter to AOM Wendy Katherine from Halton Midwives re concern with 1999 Funding Agreement and lack of coverage for miscarriages. (March 29, 1999) AOM0002084.

76 Fax from Manitoulin Midwives to AOM re: impact of travel Case Load Variables (March 24, 1999) AOM0002078.

77 Letter from AOM President Bridget Lynch to Sue Davey re: Funding Agreement Process concern by AOM (March 29, 1999) AOM0009927.

78 Letter from Bridget Lynch (AOM) to Sue Davey (Acting Director, MOH) re: concerns re: new funding agreement (March 30, 1999) AOM0001998.

79 Letter from Wendy Pinder to Bridget Lynch (April 1, 1999) AOM0001988.

80 Letter from AOM Bridget Lynch to Midwives re: Finalized Funding Agreement presented by CHB on April 1, 1999 for approval (April 7, 1999) AOM0001989.

124. In advance of the new funding agreement coming into effect, the AOM published a Practice Guide, to assist members in setting up Practice Partnership Agreements.[82] It also explains that the independent contractor relationship was necessary so as not to jeopardize the midwives' ability to carry out their model of continuity of care and 24/7 and unpredictable available to women and their infants.[83] The Guide:

(a) provides the history of devolution of LMCO to TPAs, and discusses the contractual nature of midwives (in comparison to employees).

(b) provides an overview of the 1999 funding agreement, the first funding agreement to be between MPGs and TPAs instead of the LMCO.

(c) notes that there are three types of payments - fees, disbursements and grants. Disbursements are noted to include malpractice insurance.

125. The AOM also produced for its members a Guide to Midwives Earnings and Benefits[84] and a series of Supplementary Template Documents for use with the Practice Group Partnership Agreement.[85]

126. Under the new arrangements, midwives would fill out an invoice for midwifery services, upon which they would write the courses of care, caseload variables, travel, and other details. [86]

127. On May 28, 1999, the OMP's Wendy Pindar sent a memorandum to all midwives regarding the new contract and budget application.

128. On June 1, 1999, the MPG-TPA Funding Agreement came into effect.

129. Also on June 1, 1999, the LHCHC drafted a letter to the practice groups, copying the AOM, to advise that fee level increases based on experience will now happen once per year. It also states that the Ministry will continue to pay liability insurance for midwives.[87] This completed a year and a half long process of intense negotiations between the AOM and the OMP to create a new funding agreement that reflected an independent contractor relationship, but which also protected the compensation, benefits and disbursements which had been part of

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81 MPG - TPA Template Funding Agreement (June 1, 1999) AOM0006463.

82 Association of Ontario Midwives 1999 Practice Guide (1999) AOM0000600.

83 Association of Ontario Midwives 1999 Practice Guide (1999) AOM0000600.

84 AOM Guide to Midwives Earnings and Benefits (1999) AOM0001757.

85 AOM Supplementary Template Documents for Use with the Practice Group Partnership Agreement (1999) AOM0003988.

86 Midwifery Services Invoice (1999) AOM0014270.

87 Letter from Lawrence Heights Community Health Centre to MPGs re: 1999-2000 Funding Agreement Changes (June 1, 1999) AOM0012920.

our original funding in 1994. The process was extremely demanding on the staff and costs of a very small profession. Like other midwife members of the DST, I was in an unpaid, volunteer position as AOM President, and despite the fulltime hours these negotiations required, I also had to work as a clinical midwife in order to earn an income. The small AOM membership also had to fund our legal costs.

13. Ontario Midwifery Program Submission Guidelines

130. Attached to the May 28, 1999 Memorandum above was a document prepared by the OMP for the TPAs – The Transfer Payment Agency Submission Guidelines dated May 26, 1999.[88] This document states that:

(a) one of the objectives of the OMP is to "ensure an equitable funding mechanism that supports the integration of midwifery services into the funded health system."

(b) defines "AOM" as "The AOM represents the professional interests of midwives. The AOM was instrumental in the implementation of regulated midwifery, including the development of the standards of practice, the model of practice and the methods of payment with the Ministry of Health."

(c) defines the Ontario Midwifery Program Framework as "the policy framework for funding of midwifery services in Ontario. It was developed by the CHPB and the AOM to articulate the Ontario model of midwifery practices as it relates to funding and to explain the rationale for the structure of the midwifery program."

VI. FURTHER DELAY IN OBTAINING EQUITABLE COMPENSATION

1. Introduction

131. I was involved in the efforts to bring compensation issues to the attention of the Ministry following the above-noted finalizing of the new funding agreement.

132. We had just completed two years of intense negotiations by the AOM and Ministry to renegotiate a funding agreement that maintained the integrity of the midwifery model of care and midwifery services. While the negotiations with the OMP and CHB were intense, I felt generally that I was being respected and heard as I represented the concerns of the DST, the Board and the AOM membership.

88 Guidelines by OMP re: Transfer Payment Agency Submission Guidelines (May 26, 1999) AOM0008027.

133. Nonetheless this was more than two years of anxiety which took our focus away from growing the profession and attending to a key outstanding issue – our compensation which had now been frozen for 6 years. [89]

134. During these negotiations, the AOM worked to ensure that the overall compensation that we received from the Ministry remained comparable to the compensation under the pre-existing "salary" regime. We did not want to see any reduction in compensation. It was made clear to us in our negotiations that we needed to finish the devolution process and the redesign of the compensation to an independent contractor status before we formally requested a compensation increase.

135. Although I had raised the issue of increased compensation for midwives during the devolution discussions as noted above, the Ministry would not discuss any such increases during that time. The Ministry wanted to focus first on its mandate to devolve the system while ensuring an independent contractor status for midwives. With the substantial work required to transform the contract relationship and choose and devolve to the appropriate TPAs, the issue of the adequacy of the level of the compensation was left post-devolution.

136. However, the physicians were receiving increases in compensation during this time. On April 1, 1999, the Ministry distributed a Bulletin to midwives to inform them of the OMA agreement for 1999/2000 fee increases for Physicians. An across-the-board increase of 1.45% was applied and it provided that additional funding will be used for changes to the fee schedule as recommended by the OMA.[90]

137. However, despite our timely need to pursue fair compensation at this time, we were instead inundated with the unrelenting and demanding process of the government's imposition of devolution on the midwifery sector, and the subsequent implementation of the new funding agreement and independent contractor relationship. The formal request for increased compensation would not come until the fall of 2000.

VII. DIFFICULTIES ARISING FROM THE INDEPENDENT CONTRACTOR MODEL

1. Introduction

138. In the first months of the funding agreement, there were many concerns that arose and issues that needed to be addressed. In particular, some of the administrative structures in place resulted in financial penalties for midwives and practice groups, or increased administrative workload—all related to the new status of midwives as independent contractors. Over these months, the AOM and

89 Memo from Wendy Pinderr to All Midwives re: 1999 Contract (May 28, 1999) AOM0001124.

90 MOH Bulletin 1004 to Midwives re: 1999/2000 Payments for Physician Services (April 1, 1999) AOM0002007.

I worked hard to negotiate with the government, the LHCHC and our membership to resolve these issues.

139. There are considerable difficulties that arise from the independent contractor model. These include the Ministry “billing in arrears” approach and the substantial increase in work required of midwives by the new independent contractor relationship, including substantially enhanced practice management and reporting responsibilities. Over the past thirty years, the demands and complexity of midwifery clinical work in Ontario have increased, as have the business and practice management responsibilities of midwives.

140. In September and early October, 1999, there were workshops held between the AOM and Ministry in which some of these concerns were voiced by the membership.

2. Billing at Different Experience Levels

141. The workshops yielded that there was still some confusion about how the new funding of different experience levels was supposed to operate. For example, on November 2, 1999, the AOM Board wrote a memorandum to all registered midwives advising them that they should bill according to experience level of the midwife who was care giver, as this was the advice that was given by the AOM's legal counsel.[91]

142. On November 1, 1999, the MPGs received a revised schedule C and an Amending Agreement in their budget approval packages from the Interim Transfer Payment Agency at LHCHC. At the AOM Board meeting that day, the Board instructed the Executive and staff to send out a notice of ratification vote along with a ballot on the Revised Schedule C to the membership, in accordance with the AOM Constitution. The revised schedule responded to concerns about the difficulty for new registrants to move up an experience level.[92]

3. Revising the Annual Assessment Date

143. The November ratification vote also canvassed opinion regarding the moving of the 'Annual Assessment Date', which is the universal date that all eligible midwives move up an experience level, to make it coincide with the beginning of the fiscal year. I advised Wendy Pindar at the OMP that the process was underway in a letter on November 8, 1999.[93]

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91 1999/11/02 - Letter from AOM Board to Members re: Invoicing Procedure (November 2, 1999) AOM0003674.

92 Memo to All Midwives (November 3, 1999) AOM0014284.

93 Letter from AOM Bridget Lynch to Wendy Pinder OMP Co-Ordinator, re: vote on Revised Schedule C and Amending Agreement (November 8, 1999) AOM0001996.

144. On November 9, 1999 a meeting was held between the AOM, MOH, and LHCHC at the Community Health Branch of the Ministry. At this meeting, AOM representatives expressed a concern that some practice groups, in anticipation of the approval of caseload variables, had delivered services in excess of their caseload when babies who were due in April and May—just after the turn of the fiscal year—arrived before April 1, 1999. The result was that some midwives were undercompensated for services provided. The AOM requested that the invoicing process be delayed until the appropriate spreadsheet could be amended to incorporate a line for these courses of care in the April-May spreadsheet.

145. On November 17, 1999, I wrote Wendy Pindar following up on our conversation at the November 9 meeting and reiterated this request.[94] On December 17, 1999, Wendy Katherine wrote to Wendy Pindar, once again following up on this issue, advising her that our survey of the membership yielded unanimous support for the anniversary date of April 1. [95]

4. Problems with the Billing in Arrears Approach

146. One of the biggest issues that arose from the transition to the independent contractor model was created by the "payment-in-arrears" funding model.

147. The first year of the funding agreement also made only 10 months of funding available for 12 months of operating. Midwives were experiencing such significant cash flow problems as a result, that some wrote directly to the MOHLTC, cc'ing me, to express their concerns. Some MPGs were at risk of having to stop their services, as they did not have adequate funding.[96]

148. On November 25, 1999, I once again wrote to Wendy Pindar, this time requesting that the invoicing process be amended to allow midwives to bill at the time of birth, rather than only at the time of discharge (at 6 weeks after the birth), as this limitation financially penalizes midwives.[97] In my letter I stressed that the AOM believed that the OMP was acting in good faith, but that it was imperative that the new funding model should not financially burden midwives.

149. On December 14, 1999, I wrote to Sue Davey about this issue, as I had not heard back from Pindar. I stressed that the imposed delay in invoicing was costing most practice groups an average of 15%-25% of their operational budget

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94 Letter from Bridget to Wendy (November 17, 1999) AOM0014287.

95 Letter from AOM Wendy Katherine to Wendy Pindar re April 1 as anniversary date of contract (1999-12-17) AOM0002009.

96 Letter from Womancare Midwives to S. Davey re: Transition to New Invoicing System (March 27, 2000) AOM0012926.

97 Letter to OMP from AOM Re Timing of Billing (November 25, 1999) AOM0002012.

and be without compensation for 8 to 12 weeks, "causing severe and unnecessary financial distress".[98]

150. On December 24, 1999, Pindar finally responded on behalf of Davey. She did not concede that midwives could invoice immediately after births, but instead offered that the Ministry would delay the recovery of surplus funds for the years 1997/98, 1998/99, 1999/00 and 2000/01 to ease the transition.[99]

151. On February 17, 2000 Wendy Katherine drafted a memorandum to all midwives on the history of the issues with the "payment-in-arrears" funding model.[100] Further, the memorandum notes that:

> *AOM has been informed that members have some concerns that no explanation was given for the refusal of caseload variable requests in the 1999-2000 budget approval process. LHCHC communicated its regret to the AOM that they were understaffed and unable to provide written feedback to each practice group as to why individual items in the budget submission were approved or rejected in the 1999-2000 budget.*

152. On February 18, 2000, I wrote back to Davey on this issue, advising her that this was an insufficient solution to the problem, given that most practice groups had no surplus or insufficient surplus to cover the deficit they experienced as a result of the billing model.[101]

153. On March 8, 2000, I had a teleconference with Sue Davey on this issue. In the teleconference, I explained that the invoicing system was punitive for midwives, and that they were receiving on average 15% less in compensation and 15% less in operational costs, for the work they have completed in this fiscal year, representing a total loss of several hundred thousand dollars to MPGs in Ontario. Further, despite the fact that monies will be recovered 'at the end of the day' in some future fiscal year, the current financial costs to midwives remained: Midwives received 15% less in RRSP contribution accessibility for the fiscal year of transition, our only form of pension arrangement. Over time, this represents thousands of dollars of lost pension funds to midwives in Ontario. Midwives had to take out business loans to cover the loss in operational costs. This requires paying accountants, paying the cost of the loan, and most importantly, midwives

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98 Letter from Brigitte Lynch to Sue Davey re: invoicing issues (December 14, 1999) AOM0001775.

99 Letter from OMP Coordinator Wendy Pinder to Bridget Lynch re: Transition issues (On December 24, 1999) AOM0002001.

100 Memo from Wendy Katherine (AOM) to Members re: Funding Transition (2000-02-17) AOM0003174.

101 Letter from Bridget Lynch to Sue Davey re: Transition to New Funding Model (February 18, 2000) AOM0003176.

will be required to pay out of pocket to pay off the loans, rather than carry the cost in perpetuity.

154. In this meeting, the Ministry proposed a required advance at the beginning of each fiscal year to address cash-flow problems that practice groups are experiencing with the new Funding Agreement. The following week, the AOM Board met to discuss the issue and unanimously supported the option of a required advance payment at the beginning of each fiscal year. The Board felt that a required advance of 20% to 25% would be fair, given that Article 7 of the Funding Agreement allows for a practice group to request an additional advance, if needed. I wrote to Davey on March 23, 2000 to advise her of this outcome.[102]

155. Finally, on April 3, 2000, Sue Davey contacted me to advise me that they were adding Article 5.1 to the MOHLTC/TPA agreement, so that it now allowed for an advance payment of up to 20% of the maximum annual fee payable to a given practice group.[103] Even though the issue was finally resolved, it took a year to resolve with many midwifery practice groups having to borrow funds to remain solvent. It was another year of financial duress with the AOM often coming up with solutions which would work for the government.

5. Downloading Further Costs onto Midwives

156. On December 8, 1999, the Head of the Newborn Screening Program in Ontario from the Ministry sent a letter to the AOM, to be distributed to midwives, with an accompanying email that suggested the midwives send blood samples for newborns who do not yet have health cards by courier instead of mail, to minimize delay. I raised concern with the risk that yet another cost (that of a courier) might be downloaded onto midwives.[104] For example, in a practice of 4 midwives, with 160 births per year at (conservatively) $20 per courier, this would be an additional expense of $3,200 per year.

157. Further, the TPA Guidelines for Implementation of 2000/2001 Budgets[105] make clear that:

> *Only professional malpractice liability insurance premiums are covered under disbursements. Commercial general*

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102 Letter to MOH Sue Davey from AOM Bridget Lynch re request for Fee Advances (March 23, 2000) AOM0002028.

103 Letter from MOH Sue Davey to AOM Bridget Lynch re: addressing cash flow difficulties (April 3, 2000) AOM0002019.

104 Letter from B. Lynch to all midwives re: newborn screening blood samples (December 8, 1999) AOM0002004.

105 TPA Guidelines for Implementation of 2001-01 Midwifery Practice Group Approved Annual Budgets (October 30, 2000) AOM0007891.

liability insurance (office insurance) is not funded as a disbursement.

6. Under-budgeting Birth Kits for New Registrants

158. On December 14, 1999, Wendy Katherine wrote to Cathy Paul, following up on another outstanding issue from the AOM-LHCHC discussions.[106] A birth kit for a New Registrant (that contains all the necessary clinical equipment) was initially budgeted at $4000, which came in the form of a grant from the LHCHC However, when the cost of the kits was found to be inadequate and calculated at $5250, Katherine requested, under the direction of the AOM executive, that the LHCHC forgive the difference between the new amounts for the practice groups who had covered the costs for New Registrants that year, which the LHCHC agreed.

7. The Substantial Increase in Work

159. In addition to the above issues, the new independent contractor relationship also required midwives to take on a substantial increase in work, including substantially enhanced practice management and reporting responsibilities. The AOM developed a new business administration binder to assist MPGs in running their new businesses under the new funding agreement. As new independent contractors, they had more extensive responsibilities as business partners and owners.

VIII. MIDWIVES STRUGGLE TO ADDRESS BARRIER TO DIRECT SPECIALIST REFERRALS

160. In 1998 and 1999, the AOM was also campaigning for the Ministry to revise the OHIP fee codes so that specialist physicians would be paid the same consultation fees for consultations with midwives, specialist physicians receive when family physicians consult and make a referral to them. The result of the differential in the fee structure meant that many specialist physicians were beginning to refuse to accept consultations directly from midwives and were forcing their clients to make an appointment with their family physician before the specialist would see them.[107] [108] [109] This was not only inconvenient and time consuming for the midwifery client and an additional expense to the health care system, but it also again reinforced the hierarchical structure of the health care system, where the physicians held the power.

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106 Letter from W. Katherine to C. Paul (Lawrence Heights CHC) re: outstanding issues from AOM-LHCHC discussions (1999-12-14) AOM0002005.

107 AOM Statement on re: problem with Physician Consults with Midwives (Fall, 1998) AOM0002064.

108 Letter from AOM Bridget Lynch to MOH ADM Lindberg re: remuneration of specialists for midwife-requested consultations (May 12, 1998) AOM0002062.

109 Email from K Kaufman to B Lynch on Consult Fees (1998/10/28) AOM0002066.

161. The ability of midwives to refer clients to consultations with doctors is a critical element in the integration of midwives in Ontario's health care system.

162. Although some physicians were supportive and would consult with midwives, some paid the price. The AOM received a fax on December 8, 1998 advising us that the obstetricians and family physicians at a Barrie hospital were withdrawing any mechanism to facilitate consultations with clients of midwives "in support of 3 obstetricians who had reputedly been charged with fraud by the OPP for consulting with midwives."[110] This incident prompted a meeting between the CMO, AOM and the Society of Obstetricians and Gynecologist (SOGC) to occur to discuss the issue.[111] Following that meeting, the three groups wrote a letter to MOHLTC ADMs Ron Sapsford and Mary Catherine Lindberg demanding that the Ministry meet with them to resolve the situation. [112] The AOM was in apposition where in order to ensure safe and excellent care for women, midwives had to advocate for another mechanism (see code) for physicians to earn income.

163. On February 3, 1999, the ADM, Ron Sapsford wrote to me, finally responding to the AOM's request that physicians be compensated for doing consults with midwives. In response, Sapsford said that the addition of an emergency assessment fee (not a consult, as consults can only be referred by physicians) had been endorsed by the OMA and was under consideration with the Ministry. He also made clear that a fee for non-urgent assessments could only be considered if endorsed by the OMA.[113]

164. On April 12, 1999, Wendy Katherine drafted a memorandum to the membership advising them that doctor consultations with midwives in emergency situations would now be covered, thanks to the AOM's advocacy with the OMA and the MOH.[114]

165. On April 13, 2000, I wrote to Dr. Jurgen Lontor, the Chair of the Central Tariff Committee of the OMA, requesting that he address the lack of fee codes for non-emergent physician consultant services. I impressed upon him that meetings between representatives of the Ontario Chapter of SOGC, the AOM and the

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110 Fax from Michelle Kryzanauskasto Midwives Cooperative Grey Simcome re: job action of physicians re: issue of consults (December 8, 1998) AOM0002067.

111 Fax from AOM Wendy Katherine to Midwife Michellle Kryzanausskas responding to concern re: issue of consult fees (December 11, 1998) AOM0002065.

112 1998/12/16 Letter from AOM to MOH on Doc Consult Fees Draft (1998-12-16) AOM0002068.

113 Letter to AOM Bridget Lynch from MOH ADM Ron Sapsford Re response to AOM December 18, 1998 letter re: New Code for Non Urgent Physician Consults (February 3, 1999) AOM0002085.

114 Memo from AOM Wendy Katherine to Midwives re: Physician Consults and 1999 Funding Agreement (April 12, 1999) AOM0002086.

CMO had resulted in agreement that this situation needs to be rectified as soon as possible.[115]

166. The issue was still not resolved at this time.

IX. 2000: PROVINCIAL AUDITOR REPORT ON OMP

167. In 2000, the Office of the Provincial Auditor published a Special Report on "Accountability and Value for Money" regarding the Ontario Midwifery Program. (January 5, 2000). [116] The auditor listed OMP objectives including "equitable funding mechanism."

168. The Auditor found that the Ministry had not instituted a process to collect and analyze information needed to analyze the success of the OMP and had not defined "greater equity of access to midwifery services". The response of the Ministry was to work with AOM and CMO to develop an evaluation system.

169. On February 17, 2000, Elizabeth Witmer, the Minister of Health wrote to me to notify me that the AOM may be consulted by the newly created Expert Panel on Health Professional Human Resources. Following a 1999 report by Dr. McKendry on physician supply and distribution in Ontario[117], the government responded with a commitment of $11 million to implement his short-term recommendations relating to physicians. [118]

170. In April of 2000, the AOM drafted a submission to Provincial Auditor regarding Consultation Fees with Specialist Physicians.[119] The submission detailed the serious delays in the Ministry and the Central Tariff Committee of the OMA agreeing to provide consultation fees to physicians who are consulted by a midwife. At that time, there was still only the insufficient provision of fees for 'emergency' consultations. [120]

171. The AOM also made submissions to the Auditor regarding the "Fixed Component of the Midwife Fee", "Health Human Resource Planning for Midwives in Ontario",

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115 Letter from B. Lynch to J. Lontor (Chair, Central Tariff Committee, OMA) re: Physician Consultation Fees for Midwives (April 13, 2000) AOM0010147.

116 Office of the Provincial Auditor's Special Report on Accountability and Value for Money re: 2000 OMP Program Evaluation (with MOHLTC's responses) (January 5, 2000) AOM0000601.

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

118 Letter from Elizabeth Witmer (MOH) to Bridget Lynch (AOM) re-establishment of Expert Panel on Health Professional Human Resources (February 17, 2000) AOM0014241.

119 AOM Submission to Provincial Auditor Re: Consultation Fees with Specialist Physicians. (April 2000) AOM0002088.

120 AOM Submission to Provincial Auditor Re: Consultation Fees with Specialist Physicians. (April 2000) AOM0002088.

and the "Rationale for Association of Ontario Midwives Data Collection Project."[121]

172. In May, 2000, Sue Davey sent a memorandum to the AOM that Wendy Katherine had been hired as the new Midwifery Coordinator in the CHB.

X. 2000: AOM COMPENSATION TASK FORCE

173. At the conclusion of the devolution process in 2000, the AOM was able to turn our focus to the inequitable compensation and operational funding paid by the Ministry for midwifery services. This included the ongoing freezing of our compensation while others in the health care sector including physicians were receiving substantial compensation increases funded by the Ministry. The Ministry continued to provide regular increases to physicians represented by the OMA through their regular negotiations processes and structures and conducted reviews to look at CHC physician compensation.

174. Midwifery retention and recruitment was becoming a serious concern with so many years of frozen compensation and the extensive demands of the midwifery profession and education system. The AOM was receiving communications from midwives demanding that AOM take action on compensation and other contract issues.[122] [123] I decided to set up an AOM Compensation Task Force which worked to pursue equitable compensation with the MOH. Remi Ejiwunmi and I were central to the Task Force's discussions.

1. AOM 2000-2001 Request for Compensation

175. As a result of those discussions, I wrote to Sue Davey, CHB Co-ordinator, by letters dated November 1, 2000[124], December 15, 2000[125] and January 9, 2001,[126] requesting that the Ministry address the need to provide midwives with equitable compensation including a Cost of Living Adjustment (COLA). On

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121 AOM Submission to Provincial Auditor, including sections on Consultation Fees with Specialist Physicians, Fixed Component of Midwife Fee, Health Human Resource Planning for Midwives in Ontario, and Rationale for Association of Ontario Midwives Data Collection Project (April 1, 2000) AOM0014310.

122 Letter from Community Midwives of Brantford to AOM re: Contract Issues related to compensation levels (August 19, 2000) AOM0003159.

123 Letter from Guelph Midwives to AOM re: Contract Issues (August 31, 2000) AOM0003157.

124 Letter dated November 1, 2000 from Bridget Lynch, President of Association of Ontario Midwives to Sue Davey, Coordinator, Community and Health Promotion Branch; (November 1, 2000) AOM0000672.

125 Letter dated December 15, 2000 from Bridget Lynch, President of Association of Ontario Midwives to Sue Davey, Coordinator, Community and Health Promotion Branch; AOM0010352.

126 Letter dated January 9, 2001 from Bridget Lynch, President of Association of Ontario Midwives to Sue Davey, Coordinator, Community and Health Promotion Branch, AOM0010351.

November 1, 2000, I noted the discrepancy with other health care professionals with respect to Cost of Living Adjustments:

> *As you are aware other health care professionals receive COLA on an ongoing basis. In the interest of fairness and equity, the AOM believes that midwives fees must be adjusted to acknowledge the discrepancy that has evolved over the last 6 years, since the original funding agreement.*

176. The November 1, 2000 letter also noted that there was a need to adjust the amounts paid for operating and other expenses as well to ensure equitable funding and compensation. Any shortfall in funding for expenses would have to be paid for by midwives; this is effectively a compensation decrease as the cost of goods and services increases year over year.

177. On behalf of the AOM, in this letter, I asked the Ministry to

(a) address compensation related to cost of living adjustments (COLA). This includes compensation rates for midwives, operational costs for administrative staff, rent (including inflation), reimbursement rates and OMP Incentive Grants for capital expenses.

(b) I asked the Ministry to provide COLA retroactive to 1995 across the compensation levels. The Consumer Price Index Statistics were attached. The correspondence asks the Ministry to approve retroactive increase of 1.9% per year and then annually COLA thereafter. Unlike the physicians, there was no regular process by which we could negotiate funding.[127]

178. On December 15, 2000, I wrote a second letter, which indicated that the AOM had met with the Registered Nurses Association of Ontario (RNAO) and that midwives had fallen behind Nurse Practitioners in terms of compensation. When there was no response, I once again requested a COLA adjustment.

179. Debbie Lupton, AOM Executive Assistant, acting on behalf of the AOM Executive Director, sent Wendy Katherine (now the Midwifery Program Coordinator at the OMP) a reminder email on December 22, 2000, in an attempt to get a response on the COLA adjustment request.[128]

180. I received no reply to my November and December letters. By January 8, 2001, the Executive of the AOM was becoming extremely worried about the lack of response. On this date, the AOM Executive informed members of the lack of response from CHB and advised MPGs to refrain from submitting their 2001

127 CPI Data on COLA increases from 1994 to 2000 (2000-10-20) AOM0002047.

128 Email to Wendy Katherine (OMP) from AOM re COLA increase (December 22, 2000) AOM0001299.

budgets until the Executive had an opportunity to meet with the Ministry to discuss the increase.[129]

181. Again on January 9, 2001, I requested, by letter to Sue Davey, that the Ministry consider cost of living adjustments to the fee schedule, and noted again the time that had passed with no change to midwifery funding levels. I stated that "Midwives in Ontario must continue to be compensated fairly for the services we provide to women and families in the province."[130] I requested that the Ministry sit down with the AOM in order to restore appropriate levels of compensation and funding and advised Davey that the Executive had advised.

182. The AOM continued to use the compensation framework established in the Morton Report and the September 1993 Midwifery Program Framework which incorporated both the comparators of the CHC Physician and Nurse Practitioner.

183. On January 10, 2001 Sue Davey responded by letter, declining the request for a funding increase. Rather than responding to the arguments made by the AOM, Davey stated that “currently the funding allocated to the Midwifery program is fully committed to existing services.” Davey stated, "the Ontario Midwifery Program and the Ministry of Health and Long-Term Care remain committed to the fair compensation of Ontario midwives and will continue to monitor comparable professions to ensure that the pay scale remains in line with them. At present, for example, the ministry approved scale for nurse practitioners is $57,000 to $70,000."[131]

184. This response was surprising because I never received from the Ministry any information indicating that they were in fact monitoring, nor how they were monitoring the position of the midwives in relation to other comparable professions to ensure our pay scale was in line with them.

185. In addition, I never received any information that the Ministry was monitoring our work and pay in relation to our original comparator, the CHC physician and nurse practitioners. Sue Davey was responsible for the Community Health Centres and their compensation schedules as well as for the Nurse Practitioner program. In that capacity I have since discovered that she had funded a compensation review by Hay of the Community Health Centres in 1999 and yet no steps were taken similarly for midwives. In fact, the AOM had to retain Hay and pay for Hay on its own in 2003 to do such a review.

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129 AOM Memorandum Re: COLA (January 8, 2001) AOM0003144.

130 Letter from Bridget Lynch, President, AOM to Sue Davey, Coordinator, Community Health and Promotion Branch (2001-01-09) AOM0010351.

131 Letter dated January 10, 2001, from Sue Davey, Co-ordinator, Community Health to Bridget Lynch, President of Association of Ontario Midwives; AOM0002036.

186. On reading the January 19, 2001 letter, the AOM communicated with the CHPB stating that it wanted to meet with Ms. Davey to address the issue of compensation and other matters.[132]

187. Further to the AOM's request, a meeting took place on January 25, 2001 which was attended by Sue Davey, Ontario Midwifery Program Coordinator Wendy Katherine, AOM Executive Director Alison Dantas and me.

188. The AOM provided the OMP with a documentation package dated January 25, 2001 "Summary of Issues Relating to Midwives' Compensation" which supported their request for a cost of living adjustment of 1.9% for each of the past 6 years which would result in the following scale for midwives in Ontario - $63,000 to $86,000. If the estimated COLA of 2.8% for the year 2000 was added, the scale would be $65,000 to $88,000. Instead the scale remained frozen at $55,000 to $77,000.[133]

189. The AOM package attached the Statistics Canada Consumer Price Index for Ontario and Canada from 1994 to September 2000.[134] The chart showed the position of midwives with their frozen compensation in relation to the cost of living increases since 1994. It also included:

(a) the above-noted AOM document from the Morton and Joint Funding Working Group discussions, "Midwives Compensation: Comparing Midwives with CHC Primary Care Nurses and Physicians";[135]

(b) MOHLTC "Community Health Centre Approved Salary Ranges" which was appended to the AOHC's 2000 document, "Development a New Community Health Centre, Phase II: Needs Assessment and Proposal Development",[136] and

(c) p. 30 from the 1999 Hay Group Association of Ontario Health Centres Salary and Benefit Review Report setting out Exhibit 2 – Proposed Salary Ranges/Costing.[137]

190. The Ministry took no action to increase midwifery compensation as requested.

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132 Email between AOM and MOH re meeting re: compensation (January 12, 2001) AOM0001305.

133 AOM Summary of Issues Relating to Midwives' Compensation (January 25, 2001) AOM0001303.

134 CPI Data on COLA increases from 1994 to 2000 (2000-10-20) AOM0002047.

135 AOM Funding Committee — Midwives Compensation: Comparing Midwives with CHC Primary Care Nurses and Physicians (October 22, 1993) AOM0010366.

136 MOHLTC "Community Health Centre Approved Salary Ranges" which was appended to the AOHC's 2000 document, "Development a New Community Health Centre, Phase II: Needs Assessment and Proposal Development"(September, 2000) AOM0000623.

137 1999 Hay Group Association of Ontario Health Centres Salary and Benefit Review Report setting out Exhibit 2 – Proposed Salary Ranges/Costing. (June 1, 1999) AOM0005885.

XI. 2001: MIDWIFERY SYMPOSIUM

191. As a part of my presidency, I worked to facilitate a vision of midwifery and a collaborative relationship between the CMO, the AOM and the MEP. To that end, the AOM organized a Symposium working with the CMO and MEP which took place on June 4-6, 2001 on the Model of Midwifery Care in Ontario. President Elect Remi Ejiwunmi, Vicki Van Wagner and I were on the Conference Committee, along with Robin Kilpatrick, Registrar of the CMO.

192. The Minister of Health Tony Clement spoke at that conference. The Minister's remarks referred to the great benefits and value of midwifery services in Ontario. He stated that the value of midwifery is evidenced by the fact that all midwives are currently working to capacity. The Minister also stated that "the counselling that midwives provide on nutrition, birth plans, on breastfeeding and parenting engenders healthier lives for babies and children from the outset and that is intrinsic to our prevention of health and social problems that can be costly in human terms but as well we know in financial terms as well that can inflict us down the road." [138] The Minister further recognized that women attended by midwives "have lower rates of C-Section, use pain medication less often…and leave the hospital earlier".

193. Throughout his remarks he highlighted the government's investment in midwifery and midwives valued contribution to health care. However, we were unable to reconcile the Minister's glowing remarks about midwifery and their lack of attention to our request for COLA to provide equity with other health care providers.

XII. 2001: RISE IN INSURANCE PREMIUMS

194. In February of 2001 our insurance provider, Marsh Canada, indicated to us that there would be a substantial insurance premium cost increase with the actual amount to be determined. By early March we had alerted both our members and the OMP staff (Wendy Katherine and Sue Davey) of the development. We noted that, Katherine and Davey had "stated that the Ministry will continue to uphold its current funding commitment of liability insurance premiums."[139] Midwife Bobbi Soderstrum took the lead on negotiating with Marsh Canada. As of April 2001 negotiations were on going and there had been no final approval from the Ministry as to the funding of malpractice insurance in the new year. [140]

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

139 Memo from AOM Executive to Members re: Professional Liability Insurance (2001-03-02) AOM0003128.

140 Internal AOM Email re: New Registrant Caseload and Insurance (2001-05-03) AOM0003111.

195. I wrote to Sue Davey on May 11, 2001 to request that the Ministry ensure that sufficient funding was provided in time for the increased premiums in order to not jeopardize the ability of midwives to provide midwifery care which was in high demand. Without Ministry funding, midwives could not afford the increased premiums. Under law, insurance must be in place for a midwife to hold registration with the CMO and be allowed to practice midwifery. This was potentially a crisis. On May 14, 2001, Wendy Katherine responded on Davey's behalf, advising me that they would review the terms of our proposed policy options. On July 26, 2001, Alison Dantas wrote to Wendy Katherine, confirming the annual insurance premiums per midwife and the amount outstanding for the period from July 31, 2001 to May 31, 2002.[141] In this letter, she also requests a confirmation from the Minister confirming that the Ministry will be funding this, as they had discussed verbally.

196. The Ministry finally sought Cabinet approval for increased funding and Cabinet agreed to increase the operating funding to cover the cost of the increased premium.[142] During these very tense six months of close working between the AOM and the Ministry we were able to ensure midwives could continue to practice. There was never any discussion between the AOM and the Ministry that such payments were to be considered part of midwifery compensation.

XIII. 2001: PROBLEMS IN DELAYS IN BUDGETING FOR NEW REGISTRANTS

197. By letter dated April 6, 2001, I wrote to Sue Davey regarding the serious difficulties which were being caused for New Registrant midwives, midwives and consumers as a result of the OMP's budgeting process where approvals for new registrant allocations and courses of care were not finalized generally until September of a fiscal year.[143]

198. This was a stressful and challenging issue for me that year as President, but it is an issue that continued as a yearly recurrence for years to come.

199. New midwives graduate in May of each year are unable to start work until the Ministry approves the annual funding for New Registrants. Sometimes New Registrants can't begin working until the fall, as a result of the Ministry's budgeting delays. This delay creates issues with access to care for those women who want midwifery care, and creates significant disruption and stress in midwifery practices as the practices try to book women into care without certainty

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

142 Letter from Sue Davey, Co-ordinator, Community and Health Promotion Branch to Alison Dantas, Executive Director, AOM (July 31, 2001) AOM0010396.

143 Letter from Bridget Lynch, President, AOM, Karen Kaufman, Professor and Chair, MEP and Zoe Kende, President, CMO to Sue Davey, Coordinator, Community and Health Promotion Branch Re: New Registrant Funding Allocation (April 6, 2001) AOM0010370.

about the timing of funding. It also increases the risks of new graduates leaving Ontario for work elsewhere.

200. Midwifery practices must have a budget submitted by January of each year in order to be able to take on new registrants when they graduate in May. MPGs must take their best guess as to when and whether new registrant funding will be approved in order to enroll clients into care for those graduating midwives.

201. For example, if an MPG waited for funding approval to book clients and the funding approved was given in July, the practice group would be booking clients who had due dates in March of the following year. These clients would be discharged in May of the following year (the next fiscal year).

202. Women have to wait to see if they could access midwifery care and would be turned away from care when there is a delay; or the practice might risk that the funding would come through in a timely way and book women into care; and if it did not, they had to scramble to be sure the overbooking was covered by currently working midwives that were able to suddenly increase their workload. Furthermore, the graduate would be unable to work for potentially months after graduation earning no income for 1 year after graduation; more importantly, this gap in employment occurred at a critical time when the midwife should be consolidating clinical skills following graduation. Many practices incurred personal financial risk in order to address the needs of women and newly graduated midwives and book clients not knowing when and if funding will come.

203. It is an example of the Ministry program funding did not take into account the needs of pregnant women. Pregnancy and the six week post-partum period do not neatly fit into a Ministry budget year cycle. And it is these women, and their midwives that must deal with the stressors, risk, and implications when the Ministry goes not attend to the unique pregnancy-related needs of this program. It is an example of how midwives have had to provide stewardship for this women's program that the Ministry is neglecting, in contrast to the power and attention given to OMA interests and requests/requirements.

XIV. ONTARIO MIDWIFERY PROGRAM IN THE CONTEXT OF INTERNATIONAL MIDWIFERY

204. As noted in Part I, I have extensive international midwifery leadership experience. I have reviewed the expert report of Candace Johnson and have the following comments:

205. I have extensive knowledge of the Ontario midwifery system and model of care in relation to international models of maternal health and newborn care based on my work with the International Confederation of Midwives developing global standards for the education and regulation of midwives in all countries and my work as a Board member with the Partnership for Maternal Newborn and Child Health Secretariat of the World Health Organization. In this latter role, I worked to

further the vision of achieving the United Nations Millennium Development Goals (MDGs) 4 and 5, to reduce child mortality and improve maternal health, with women and children enabled to realize their right to the highest attainable standard of health.

206. Relative to international models of maternal health, the Ontario midwifery system is exceptional and renowned for both its evidence-based and client centred approach. Through the exceptional political advocacy of many women, Ontario midwives enjoy a direct-entry, independent, self-regulated professional model. Unlike some other jurisdictions, midwifery in Ontario is not beholden to either physician or nursing associations, in spite of attempts to exert control over the development and or growth of the profession.

207. The training that Ontario midwives receive is in the top ranks of midwifery education in the world. In its development, we examined many other models of midwifery, including those in Holland, Denmark, New Zealand and the United Kingdom. The Ontario educational program has a strong scientific, evidence-based focus combined with a strong culturally sensitive women's/birthing parent's empowerment and client-centred approach.

208. Health care around the world is becoming increasingly privatized. In many countries where midwives were traditionally the primary providers of maternity care and women's healthcare more generally, but midwives do not have their own, self-regulated profession, physicians are increasingly the main obstetric care providers within for-profit, private clinics. This is the case in Chile and Argentina, where these changes have largely been the result of free trade agreements across the Americas region. Midwives are losing status and their compensation is not keeping up with the private sector, causing many midwives to work only in the private sector. This is also the case in many countries across sub-Saharan Africa.

XV. PERSONAL IMPACT OF INEQUITABLE COMPENSATION

209. The personal impact of the inaction of the government to provide equitable compensation and funding of midwifery has been particularly devastating for me.

210. I have spent the last 40 years of my life as reflected in my affidavit working to develop a profession that respects women by putting them at the centre of care, by making sure they are being treated with respect. I along with my Ontario midwifery colleagues have taken an irrefutable lead in providing informed choice and respecting the autonomy of people receiving health care in this province, aspects of care that are now considered fundamental to the provision of health care in Ontario and Canada. We led the way by entrenching those aspects of care into our standards of practice in 1994.

211. I find it very disturbing that given all those contributions, I am having to prepare an affidavit and testify more than 20 years later so that my human right to fair and

equitable compensation and that of other midwives can be secured. In many ways it feels that I am reliving the fight for women to be listened to and treated fairly. I feel the same disregard that I felt from obstetricians and nurses and in many ways, it is once again demeaning.

212. It seems to me that I am reduced to feel like a beggar in my own province, when it is the government who promises equity that should be ensuring it is delivered. I feel it is very unfair to make me and my colleagues spend endless hours and our hard earned and inequitable resources to bring this application and respond to all the government's arguments when it is the government's responsibility to ensure my human rights are protected.

213. I am closing in on retirement as a woman who has spent her life advocating for women and midwifery, who fought long and hard for the recognition of the profession. I feel quite angry that that I have not been able to reap the full reward of the compensation owing to me and now must spend my time and money fighting the government for equity. I feel very deeply the lack of respect for my work and that of other Ontario midwives which are our inequitable compensation reflects. I don't feel I deserve to be treated this way. I feel that the government is taking advantage of our skills and commitment to excellent care because they want to use them to deliver on their promises for better health care but without having to pay the price the work deserves.

214. I have travelled the world, extolling the virtues of the government's Ontario Midwifery Program, explaining to other governments and ministries of health how well the AOM worked with the Ontario Ministry of Health to develop the best model of midwifery in the world. I have seen in these travels how our model of midwifery has inspired governments to develop strong midwifery professions in their countries. I have also seen how the midwives in these countries have historically been poorly treated and poorly compensated. Sadly, they are women and all too used to being poorly treated and compensated. More concerning is that midwifery in those countries is no longer attracting the best and brightest young women into their ranks. No matter how good a program, the profession rests on how well regarded and respected it is, and that includes compensation that is equitable to the work provided. So midwives from around the world continue to look to Ontario for inspiration, for ways in which they can put pressure on their governments to treat them fairly with not only adequate, but equitable compensation.

215. I want to be able to know that I no longer have to worry about whether my compensation is equitable because the government will in the future have processes in place to ensure that it is – without me having to sue them to get action. The struggle for equity should be past. As a human race we have so much more important work to do.

SWORN this 28th day of July 2016.

A Commissioner for taking Affidavits.

Bridget Lynch