

In the matter of an application under section 34 of the Human Rights Code to the
Human Rights Tribunal of Ontario

**THE ASSOCIATION OF ONTARIO MIDWIVES ACTING ON BEHALF OF
COMPLAINANT ONTARIO MIDWIVES ("AOM")**

Applicant

**HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, AS REPRESENTED BY THE
MINISTRY OF HEALTH AND LONG TERM CARE ("MOHLTC")**

Respondent

OPENING STATEMENT OF THE ASSOCIATION OF ONTARIO MIDWIVES

"In 2016, women shouldn't have to fight to be paid fairly for their work"

Renu Mandhane, Chief Commissioner, Ontario Human Rights Commission, April
19, 2016, Ontario Equal Pay Day Statement

JUNE 1, 2016

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Introduction

a. The Complainant Midwives

1. This Opening Statement is presented by the Association of Ontario Midwives on behalf of 774 complainant midwives who allege that their human right to compensation free of sex discrimination – that is “pay equity” has been violated repeatedly and systematically through actions and inactions, policies and practices over the last 20 years by the Ministry of Health and Long Term Care.

2. The impact of the Ministry's actions is and was that the gender of the midwives and the women for whom they work substantially lowered their pay relative to the value of their work – that is, the midwives' compensation was and is discounted as a result of their gender – an unlawful gender penalty. By systematically and knowingly underfunding midwifery compensation relative to other key comparators, the MOHLTC perpetuated the historical and ongoing disadvantages experienced by the almost exclusively female dominated profession of midwifery.
3. Pay equity or the right to be free from sex-based discrimination in compensation is a fundamental human right guaranteed by the *Human Rights Code* and the *Pay Equity Act* where applicable to all Ontario women. Here the *Code* is the applicable governing law.
4. The systemic discrimination that infuses midwives' compensation acts as a barrier to their full and equal participation and integration into Ontario's health-care system and more generally in society. As stated by the Pay Equity Hearings Tribunal, fair pay is not only necessary to meet the necessities of life but also guarantees a sense of dignity and recognition for the value of the work women perform.
5. This case has been brought to close the midwifery gender pay gap experienced by midwives and to ensure it never reopens. Adjustments required to close the midwifery gender pay gap are a *Human Rights Code* remedy and not a "pay increase" and therefore should not be considered to fall within the Province's compensation restraints or net zero policies.
6. The complainants range from recent new registrants to the "grandmothers" of midwifery who helped advocate for, design and implement the regulated and funded Ontario Midwifery Program which commenced on January 1, 1994. A list of these midwives and their practice groups is set out in Appendix 1 to this Statement.
7. These 774 complainants and the rest of Ontario's regulated midwives work or have worked in practices across the province providing MOHLTC managed midwifery health care services for Ontario women. This case focuses on the impact of gender discrimination on midwifery pay, however, not all midwives or midwifery clients are women. There is one male midwife in Ontario. Some midwives and clients are transgender or do not identify as women. Trans people experience societal and systemic marginalization, including in health care and in the labour market. Midwives who are transgender will also experience this gender penalty.
8. Midwife means "with woman". Midwifery promotes normal childbirth and the prevention of health problems. In 1994, midwifery became part of the Ontario regulated and funded healthcare system and is provided free of charge to residents of the province. Midwives provide care in the hospital, birth centre and

home setting.¹ Midwives are expert specialists in normal pregnancy, birth and newborn care and trained in emergency management. Midwifery care is rooted in the most current maternal and newborn care research and evidence.

9. There are over 800 registered midwives in Ontario, serving communities through 90 clinics across the province. Since 1994, more than 150,000 babies have been born under midwifery care, including more than 35,000 births at home.
10. Each year, the number of practicing midwives increases as new registrants start to practice. Since regulation, the demand for midwifery has continued to grow at a high rate. The MOHLTC has stated that 35% of pregnant women in Ontario who seek midwifery services are unaccommodated.² Midwives are a key part of the Ministry's health care human resource plan to address the shortage of family physicians willing to provide maternity and intrapartum care and the dysfunction and cost of having obstetricians who are high risk specialists provide low risk maternity care. Since 1994 there has been and continues to be an extreme shortage of midwives relative to consumer demand

b. The Association of Ontario Midwives (AOM)

11. The Association of Ontario Midwives ("AOM") is the recognized representative of Ontario's registered midwives and has existed since 1984. The AOM advocates for the professional and employment interests of midwives who are designated as independent contractors to protect their model of care.
12. Because birth cannot be scheduled, and the Ontario midwifery model of care standard provides for continuity of care, informed choice and choice of birth place, midwives are on-call 24/7. The needs of women in midwifery care and the standards upheld by midwifery to respond to those needs does not permit midwives to be governed by the *Employment Standards Act* in its current form. Accordingly, the AOM, similar to the Ontario Medical Association, is not a certified bargaining agent under the *Labour Relations Act* although it has engaged in a form of bargaining with the MOHLTC for many years.
13. The AOM represents the interests of midwives and the profession of midwifery regarding funding for midwifery services and does this by negotiating with the MOHLTC concerning, amongst other matters, the funding the Ministry pays to midwives for their compensation.

1 Ministry of Health and Long-Term Care, "Midwifery in Ontario: What is a Midwife?", accessed at <http://www.health.gov.on.ca/en/public/programs/midwife/> ; Ontario Hospital Association, College of Midwives of Ontario & Association of Ontario Midwives, "Resource Manual for Sustaining Quality Midwifery Services in Hospitals", September, 2010.

2 Unaccommodated client data was collected by the MOHLTC in its Midwifery Outcomes Reports ("MOR") which is now BORN. See "Minister's Office Foundation Statement on OMP, presentation by MOHLTC, December 20, 2013, p. 2

14. The AOM provides ongoing professional development, resources and clinical practice guidelines, public education, and promotes accessibility of midwifery care for women in Ontario.³

c. The Ministry of Health and Long Term Care (MOHLTC)

15. The MOHLTC sets the compensation and funding of midwifery services and manages the Ontario Midwifery Program (OMP). For the period from before regulation to a number of years ago, the MOHLTC Community Health Branch (CHB) (later renamed the Community Health and Promotion Branch (CHPB)) was responsible for both the OMP and the Community Health Centre (CHC) program.
16. The MOHLTC has pursued primary health care reform since the 1970's. Such reform aims to achieve an integrated patient-centred system that supports healthier patients, faster access and the right care at the right time at the right place.⁴ The regulation and funding of midwifery services and the Community Health Centres which started around 1979 are major building blocks of that reform process.
17. In the early 1990's the Ministry's Women's Health Branch worked with the CHB and the AOM and consumer group the Midwifery Task Force of Ontario to develop the midwifery practice framework and compensation system. The Ministry is responsible for the setting of compensation of the CHC salaried physicians and nurse practitioners who were found in 1993 to be the key comparators for setting midwifery compensation as of regulation starting in January, 1994.
18. The Primary Health Care Branch then replaced the Community Health and Promotion Branch and became responsible for stewardship, funding and managing of the OMP and the CHC programs. This Branch reported until recently to an Assistant Deputy Minister (ADM), Negotiations and Accountability, Management division. The OMP and the Community Health Centre programmes report to the Primary Health Care Branch which now reports to the Health System Accountability and Performance Division.

d. Structure of this Opening Statement

19. Given the complexity of this Application claiming systemic gender discrimination in compensation and the delays under further hearing dates will commence, this Opening Statement is constructed to provide a more detailed understanding of the AOM application, the MOHLTC response, the historical and contextual

3 See AOM website - <http://www.ontariomidwives.ca/care/> for extensive resource materials and videos on midwifery.

4 see 2012 Action Plan for Health Care
http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf

human rights considerations; the patterns of MOHLTC actions and inactions which produced the systemic gender discrimination in compensation midwives have experienced over the last 20 years and the legal framework within which that evidence should be considered.

20. Since the Application was filed and further to the AOM's June, 2014 Request for Production and Tribunal Case Management Directions, the AOM has received and is continuing to receive substantial documentary production from the MOHLTC. These documents have only served to reinforce the AOM claims of inequitable treatment. Documents received from the MOHLTC in the past week have shown new calculations and evidence of increased compensation and benefits provided to CHC physicians which will change the calculations of the midwifery gender pay gap and the remedial and retroactive compensation owing. Over the summer as this document production is completed, the AOM will provide a further revised calculation of the gender pay gap based on the updated figures and calculations.

Part 1 Nature of AOM Evidence

a. AOM Non Expert Witnesses and Overview Summary of Evidence

21. In light of the complexity of the issues and the extensive history required to address appropriately the systemic issues in this case, the AOM developed an Overview Summary of Evidence provided to the MOHTLC and Tribunal on September 17, 2015. This document which is attached as Appendix 2 to this Opening Statement provides a chronological summary which highlights some of the key evidence which the AOM will be leading through its various witnesses apart from its expert evidence which is described below. The AOM also filed Individual witness statements which need to be read in conjunction with this Overview Summary. These statements include matters in addition to those set out in this Summary. The AOM will now be filing Affidavits for all these witnesses.
22. The AOM's witnesses who have been associated with the AOM over the years since pre-regulation are as follows: Jane Kilthei, Vicki Van Wagner, Bobbi Soderstrom, Carol Cameron, Bridget Lynch, Remi Ejiwunmi, Elana Johnson, Katrina Kilroy, Lisa Weston, Madeleine Clin, Elizabeth Brandeis, Kelly Stadelbauer and Juana Berinstein.
23. In addition, the AOM filed witness statements from representative midwives which were filed at the time of the AOM's November 2013 application to represent the injury to dignity claims of all the complainants, namely Daya Lye, Tracy Pearce-Kelly, Nicole Roach, Maureen Silverman, Rebecca Carson and Jackie Whitehead.
24. Other AOM witnesses are: John Ronson, lead consultant on the Courtyard Report; Moshe Greengarten, lead consultant Hay Group; Theresa Agnew,

Executive Director of the Nurse Practitioners Association of Ontario; and Neil Patton, external negotiator retained by AOM.

b. AOM Expert Evidence

25. The AOM has also filed the following expert reports on which it relies:
 - (a) The initial report of Mr. Paul Durber dated November, 2013 and his subsequent report dated March 30, 2015 which responds to the November, 2014 MOHLTC expert reports of Bob Bass, Dr. Richard Chaykowski, Dr. John Kervin and Dr. David Price.
 - (b) The November, 2013 report of Hugh Mackenzie (revised as of March, 2015) as well as his responding report dated March 30, 2015 which responds to the November, 2014 MOHLTC reports of Mr. Bass, Dr. Chaykowski and Dr. Kervin.
 - (c) The initial report of Dr. Pat Armstrong dated March 2, 2015.
 - (d) The initial report of Dr. Ivy Bourgeault dated March 30, 2015.
26. The AOM experts have not yet replied to the August, 2015 further MOHLTC expert reports.
27. Attached as Appendix "3" is a summary of key findings of these expert reports.

c. Agreed Facts Which Support the Claim of Systemic Gender Discrimination in Midwifery Compensation

28. The AOM and the MOHLTC have agreed to date on certain facts as a result of the MOHLTC's statements in its February, 2014 Response Form 2 stating certain agreements to text in the Applicant's November, 2013 Schedule A, Facts and Issues, as well as the agreements or statements of substantial accuracy which were included in the MOHLTC December 4, 2014 Response to Particulars Re: AOM Application. See Appendix "4". AOM Pleaded Facts Which Have Been Specifically Agreed To In MOHLTC Pleadings Or Have been Agreed as Substantially Accurate or Accurately Stating Contents of Documents
29. The parties are also in the process of trying to work out further agreed facts. Now that the hearing is moving to an affidavit process, the AOM is requesting that the exchange of affidavits include a process to identify what portions of the affidavits can be agreed to by parties and thus limiting the areas for disputed evidence.

d. Government Decision-Making Documents Which Support the AOM Claim

30. The MOHLTC has produced on an AOM Motion for Production and as part of its duty to produce documents, extensive cabinet and MOHTLC midwifery

compensation setting documents which confirm many of the factual statements and principles stated by the AOM in its Application Schedule A and also contradict many of the statements made by MOHLTC expert reports which purport to take a view on what might be the reason for the Government's decision to pay substantially more compensation to CHC physicians than to midwives.

31. Key excerpts from Government produced documents are set out in Appendix 5. There are many further documents which have been produced by the MOHLTC and which overall support the AOM's claims of unequal treatment in relation to the setting of the compensation of midwives over the period since 1994 up to the present. Those documents which the AOM seeks to enter as evidence will be provided to the MOHLTC and Tribunal by the end of July, 2015 along with

e. Focus on Midwifery Work

32. This Statement initially focuses on reviewing the work, scope of practice and education of midwives. There are so many misunderstandings, prejudices and stereotypes about what midwives do compared to physicians, it is important in this human rights proceeding that the actual work and qualifications of midwives are highlighted. AOM witnesses will also provide extensive information with respect to this. This midwifery work along with CHC Physician and Nurse Practitioner work is also detailed in the Durber Report and its various Annexes. Pay equity is about making visible and valuing women's work so that it is compensated properly and fairly

Part 2 Making Visible Midwives and their Work in the Health Care System

a. Autonomous and Specialist Health Care Provider

33. Registered midwives are autonomous primary health-care providers who are specialists in providing comprehensive around-the-clock, on-call, maternity care for women with low-risk pregnancies.⁵ Along with family physicians and obstetricians, they provide primary maternity care in Ontario's funded health-care system.⁶ As well, like paediatricians and family physicians, they provide primary health care to new born infants up to 6 weeks. The knowledge and skills of midwives cross a number of professional boundaries, including family physicians, obstetricians, pediatricians, nurse practitioners, and registered nurses and registered practical nurses.

5 Note: Some Aboriginal Midwives because of their unique status are exempt from the above-noted licensing requirements and are not covered by the compensation structures at issue in this application. See Association of Ontario Midwives, "Aboriginal Midwives - transforming care and healing communities", accessed at <<http://www.ontariomidwives.ca/care/aboriginal>>

6 Nurses also play a key role in the maternity health-care system. However, they are not primary care providers through the prenatal, antenatal and postpartum period. See Courtyard Group Ltd., "Compensation Review of Midwifery", September 2010.

34. Originally, in Ontario, midwives were the primary providers of maternity care up to 1865. After that, the primary model became the physician-nurse model. Since 1994, both models exist in Ontario. The 1987 Task Force Report on the Implementation of Midwifery in Ontario (TFIMO) chaired by Mary Eberts and relied upon by the Government as the basis for the funding and regulation of midwifery states:

*.....the movement to recognize midwifery in Ontario has a wider context. It has to do with re-establishing a traditionally female occupation that developments in medicine and medical technology threatened to extinguish. More fundamentally it has to do with changes in how society views childbirth itself."*⁷

35. In Ontario, if a woman is in midwifery care she will not see a physician unless there are concerns or complications that fall outside the midwifery scope of practice. Midwives are the only regulated primary health care providers who attend at home births or birth centres in Ontario. Midwifery care is organized so that the client will be attended during the birth by a midwife known to her. The medical led model does not have that requirement.
36. In midwife-led maternity care, the midwife is the most responsible health-care professional in planning, organizing and delivering maternity and newborn care. In physician-led models of maternal care, an obstetrician or family physician has those responsibilities and is supported by nurse practitioners, registered nurses and registered practical nurses and at times other health care workers. This is also the model of infant care by family physicians or paediatricians. Family physicians generally provide prenatal and post-partum care with only a small minority providing intrapartum care.
37. A full time midwife typically attends upwards of 80 births per year. This means that she will attend one to two births per week on average. However, births are unpredictable; a midwife may have an on-call week without any births to attend or she may have an on-call week with more than 7 births to attend. The labour and birth may come in the middle of the night, on weekends or statutory holidays. This unpredictability and on call demand is very onerous.
38. While ensuring constant access to a known midwife can at times be challenging for midwives to facilitate, the midwifery model of care in Ontario consistently demonstrates excellent clinical outcomes, cost-effectiveness and high rates of client satisfaction.

7 Task Force on the Implementation of Midwifery in Ontario, 1987.

b. A Unique, Onerous and Highly Successful Model of Maternity Care

39. Midwives provide midwifery care in accordance with the *Midwifery Act, 1991*⁸ and the *Regulated Health Professions Act, 1991*.⁹ That Act set out the following definition:

The assessment and monitoring of women during pregnancy, labour, and the post-partum period and of their newborn babies, the provisions of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries.

40. "Midwife" is a protected term under the *Act*. A physician or nurse is not allowed to practice midwifery without obtaining the necessary qualifications, clinical experience and CMO registration.
41. The Midwifery model of care is different from that of other healthcare professionals such as family physicians or obstetricians, who may care for female clients with regards to childbirth, but who do not operate within a model of care that is focussed on engendering maternity care for women and ensuring that it produces equitable outcomes for them.
42. The model of midwifery practice in Ontario is defined by the College of Midwives in a standard¹⁰ and involves providing primary maternity care services in the community. The standard includes the provision of continuity of care, informed choice and choice of birth place. The compensation structure for midwives was initially developed by the MOHLTC working with the AOM to reflect and support these principles, within the context of a government managed, community-based primary health care program.
43. The MOHLTC describes these principles as follows:

Continuity of Care

Midwives usually work in small groups and are on 24-hour call. A pregnant woman will get to know a small group of midwives (2-4) to ensure that she is comfortable and familiar with the caregivers who will attend her birth. Generally, two midwives will attend each birth and share the care throughout the pregnancy, labour, birth and after the birth for six weeks. They will offer education, counselling, advocacy and emotional support. Each midwife will take the time to build a relationship of trust and safety with each woman. If medical problems

8 *Midwifery Act, 1991*, S.O. 1991, Chapter 31.

9 *Regulated Health Professions Act, 1991*, S.O. 1991, Chapter 18.

¹⁰ <http://www.cmo.on.ca/members/standards-of-practice/midwifery-model/midwifery-model-of-care/midwifery-model-of-care-2/>

develop during pregnancy, labour, birth or postpartum, midwives work closely with specialist physicians and nursing staff.

Informed Choice

Midwives encourage each woman to take an active part in her care throughout her pregnancy and birth and will provide information to each woman so that she can make choices about her care. Midwives provide sufficient time during prenatal care to discuss questions about important issues like nutrition, birth plans, breastfeeding and parenting. Midwives recognize and support the mother as the main decision-maker.

Choice of Birthplace

The pregnant woman chooses whether she wants to give birth in a hospital or at home under the primary care of the midwife. Midwives are trained to attend births in both places as well as to help individual women choose the safest place for them. Many women who opt to have a hospital birth spend time at home with their midwife before going to hospital.

A midwife's training prepares her to be responsible for decisions about labour, delivery, postpartum and newborn care both at home or in hospital. A midwife works closely with other community midwives, doctors and nurses to maintain a high standard of care.¹¹

44. These principles are set out in the CMO Philosophy of Maternity Care.
45. In addition to the above principles, midwifery is also based on the following principles: spending sufficient time with women so that they can make informed choices about care; and, to build a partnership, appropriate use of technology and evidence-based practice.
46. The job content of midwifery work – health care for women and newborns, including vulnerable populations, involves complex, overlapping and multi-level technical medical, nursing and counselling skills integrated with continuous caring, nurturing, and comforting that are frequently invisible to those not doing the work. It is this work that the AOM's Durber report captured and the MOHLTC experts ignored and/or did not understand.
47. Central to the model of care is the need for the midwife to build a relationship of trust with the woman and empower her to make the appropriate choices for her pregnancy, birth and care of her infant to 6 weeks. This also includes providing clear recommendations and specialized guidance as to what is medically appropriate and safe. Midwives become engaged in women's lives in order to

11 Ministry of Health and Long-Term Care, "Midwifery in Ontario: What are the Principles of Midwifery Care?" <<http://www.health.gov.on.ca/en/public/programs/midwife/>>.

address the larger contexts of women's lives that impact their health and wellbeing. This includes using social work and networking skills to address the impacts of depression, anxiety, low-income, precarious work, inadequate housing, addiction and abuse.

48. This requires midwives to continually diagnose conditions throughout the course of care and to continually assess whether something remains in the midwifery scope of practice or requires a duty to consult or transfer care. This requires a systematic diagnostic method using evidence such as symptoms, patient history, contextual factors and medical knowledge to choose the correct course of action.
49. The work of midwives is typified by three integrated factors relating to sex and gender ("gendered trifecta"): work by women, for women and as it relates to women's health.¹² Midwives recognize the pregnant client as the primary decision maker and in order to provide informed choice, must take the time to establish a strong relationship of trust with each client.
50. To satisfy the CMO's continuity of care requirement, clients must have access to a known midwife at all times during their pregnancy and labour, and for 6 weeks postpartum. For the client, this means she can reach a care provider who she knows at any time during the day or night for support and care for herself or her newborn, and expect to be attended throughout active labour by a midwife with whom she has an established relationship.
51. Midwifery work is different from the work of physicians and nurses in the medical led model of maternity care. Unlike the usual focus of the physician-nurse-hospital model, the midwifery model of care mandates the building of confidence in women, providing enriching, personalized care that supports fewer medical interventions, and empowering women to feel valued and in control. The work typically occurs in the community setting. Often called upon to perform tasks simultaneously, midwives are always engaged in women's lives doing the "caring" work, which is systematically integrated into the specific medical and nursing tasks required throughout the "course of care" for each woman and her newborn.
52. While you will hear the MOHLTC CHC physician witnesses state that they also "care" during the performance of their work, which is of course true, the medical model of health care does not embed women focussed "care" and women's "empowerment" responsibility in the same way it is embedded in the regulated model of midwifery care.
53. Midwives take the needs of the woman or pregnant person as the core tenet of their model of care, and work to engender healthcare by emphasizing continuity of care, informed choice, and choice of birth place. Midwifery is not only closely

12 Note: midwives may be transgender and may care for a transgender person. Transgender people are also subject to forms of discrimination.

connected to the women they provide care for, but is acutely tied to collaborating with the client and addressing their health care needs and overall well-being which have otherwise been historically undervalued.

54. For the midwife, this means working alone or on a team to provide comprehensive care and constant availability to pregnant, laboring and postpartum clients. A typical day may include running a prenatal clinic and providing postpartum care at home to a number of clients, while simultaneously addressing the urgent concerns of clients by telephone and in person. To accomplish this, midwives carry a pager at all times, or if working in a group must ensure their on-call schedule provides access to a known midwife at all times for all clients. If the midwife reaches a point where she must go off call, usually due to sleep requirements, she has a professional and ethical responsibility to bring in another midwife known to the client to take over.
55. Midwives are trained to manage emergencies, including at out-of-hospital births. They deal with miscarriages and stillborn babies. It is generally accepted using the World Health Organization data, that approximately 70-80% of births in Ontario start out as low risk.¹³ These are eligible for care within the midwifery scope of practice.¹⁴ Data shows that approximately 67% of the births obstetricians attend are low risk, even though they are trained as high risk specialists.
56. For midwives, a low-risk pregnancy definition is based on the requirements for consultation and transfer outlined in the College of Midwives of Ontario's Consultation and Transfer of Care standard (CTCS) (January 2015).¹⁵ The inclusion and exclusion criteria, based on the CTCS, are quite broad and meant to capture typical, real-life midwifery care, which includes a number of complications of pregnancy that are routinely managed by midwives with consultant support (such as diet-controlled gestational diabetes or mild gestational hypertension). This low-risk profile provides an estimate of the proportion of pregnancies that midwives could be caring for and also to identify the proportion of low-risk pregnancies currently managed by obstetricians.
57. The above-noted low-risk profile is designed to reflect the full midwifery scope of practice, however, some Ontario midwives' scope is limited by hospital protocols or physician practices: For example, while midwives are trained to manage epidurals and medically induced or augmented labours, some hospitals require

¹³ See Executive Report of the Ontario Maternity Care Expert Panel "Emerging Crisis, Emerging Solutions, September 6, 2006.

¹⁴ BORN database, 2013 – 14 data, using the CMO definition of low-risk referred to in Overview Summary of AOM Witness Evidence, Appendix 2

¹⁵ <http://www.cmo.on.ca/members/standards-of-practice/clinical-practice/consultation-and-transfer-of-care-under-review/>

transfer of care to a physician in these cases even though a transfer is not medically indicated.

58. Family physicians and midwives focus on low risk pregnancies with a referral or consultation with an obstetrician or other physician specialists as required. As noted above, the CMO stipulates when care falls outside a midwife's scope of practice and whether she is required to consult or transfer care and to manage various complications. Midwives are trained to identify complications and risks. For example, they manage most postpartum hemorrhages within the scope of midwifery practice without referral to an obstetrician. Even in the case of a transfer, a midwife will continue to provide support and she will resume primary care when possible.
59. Government documents confirm that it is precisely this unique model of care midwives provide and their onerous and demanding 24/7 on call midwifery care that produces the successful midwifery outcomes which are acknowledged by the Government to produce the best outcomes for women.¹⁶
60. While only 5.9% of family physicians provide intrapartum care, most family physicians, if they provide prenatal care, transfer care of those patients to an obstetrician at 28 weeks, the start of the third trimester or refer to an obstetrician or midwife once pregnancy is confirmed.¹⁷

c. Education and Knowledge

61. Midwives have a specialist intensive professional baccalaureate degree (Midwifery Education Program); one year of postgraduate mentoring and practice; and engage in ongoing education and upgrading as required by the extensive standards, guidelines and protocols of the College of Midwives of Ontario. In addition, other midwives trained outside of Ontario are qualified through the International Midwives Pre-Registration Program.¹⁸
62. Nurses, Nurse Practitioners and other health care professionals including physicians with pre-existing labour and deliver experience are required to take a two year intensive accelerated program (equivalent to three years as 6 terms) plus the postgraduate mentoring and clinical practice in order to qualify to be a registered midwife and provide midwifery care in accordance with the CMO standards and practices. This option only became available around 2009. Before that, they were required to enrol in the full 4 year baccalaureate MEP. Some

16 2003 Ontario Midwifery Program Evaluation. See Appendix 5 for further examples of this.

17 2011-12 Family doctors providing intrapartum care: 5.9 % Ob-gyn providing intrapartum care 74% Family doctors billing prenatal care: 55.3% Ob-gyns providing prenatal care: 81.3% Source: Stan Lofsky – Obstetrical HHR trends in Ontario

18 <http://www.cmo.on.ca/becoming-registered/access-to-midwifery-in-ontario/internationally-trained/internationally-trained-midwives-applying-for-registration-in-ontario-as-midwives/>.

foreign trained doctors have been accepted to the MEP and some to the accelerated program.

63. The AOM will lead evidence about the scope and complexity of midwifery education which will dispel many of the misleading facts and statements which are contained in the MOHLTC pleadings and MOHLTC expert reports and witness statements about the comparison of that education and knowledge base to CHC physician education and knowledge base.
64. Although this point is never acknowledged by the MOHLTC's expert reports which criticize Durber's consideration of midwifery education to physician education, It is important to note that the AOM has always acknowledged that family physician education and knowledge is greater than that of midwives. Mr. Durber in fact ranked the CHC family physician on the Knowledge factor **three levels higher than that of the midwife. (Level 10 versus Level 7).**¹⁹ This difference in education and knowledge level was also taken into account by the MOHLTC when midwives' pay was initially set relative to CHC family physicians.

d. College of Midwives of Ontario Standards and AOM Practice Guidelines

65. The Interim Regulatory Council of Midwives (IRCM) reported to the Women's Health Branch in the early 1990's. The IRCM developed the Midwifery Model of Practice, basing it substantially on the pre-regulation Model of Midwifery developed by the AOM. That model drew heavily from both the Model of Midwifery in the Netherlands (which had some of the best outcomes and lowest intervention rates globally) and extensive input from Ontario childbearing women. The IRCM also developed the interim Standards and Guidelines of Practice which relied heavily on the standards and guidelines already developed and applied by the AOM which was self-regulating prior to regulation. These Standards and Guidelines were subsequently adopted by Transitional Council of the College of Midwives and then the College of Midwives of Ontario in 1994 at the start of regulation.
66. Core competencies for midwives informed the midwifery standards and the development of the MEP. "Core Competencies: A Foundation for Midwifery Education – Recommendations of the MIPP to the IRCM", March 1993 details a nine page list of entry level core competencies to be used as guidelines for midwifery education and evaluation, describing the skills and knowledge required by the entry level midwife. Competencies were organized by these categories: general competencies; education and counselling; collaboration with other caregivers; antepartum care; intrapartum care; postpartum care of the newborn; postpartum care of the mother; sexuality and gynecology; professional, legal and other aspects. These entry level competencies were used by the Joint Working

19 See Paul Durber, Reply Report, at p. 40.

Group as part of its evaluation of the skill, effort, responsibility and working condition of the midwives, who had not yet started working as regulated midwives.

67. These Core Competencies were used to inform the development of the Midwifery Education Program (MEP). These Competencies were formally adopted by the College of Midwives in 1994 at the start of regulation. They were subsequently updated when the Canadian Midwifery Regulators Consortium issued the “Canadian Competencies for Midwives” in 2005 and then updated in 2008. These were adopted by the CMO.

e. Current Scope of Practice, Guidelines and Standards

68. In June, 2014, the CMO Council issued updated and consolidated Guidelines and Standards of Practice.²⁰

f. Changes to Scope of Practice, Standards and Guidelines since 1994

69. Over the period since 1994, the College of Midwives of Ontario has frequently amended the scope of practice of midwives. This included but is not limited to the following key changes:
- (a) Addition of the medication Carboprost for the treatment of postpartum hemorrhage (2003)

20 Consultation and Transfer of Care Standard (formerly the IMDCTC) – revised May 28, 2014; (ii) Practice Protocols – revised May 28, 2014 Midwifery Model; (iii) Midwifery Act; (iv) Midwifery Model of Care •Continuity of Care (January 2014);(v) Definition of the Midwife (International Confederation of Midwives); (vi)Home and Out-of-Hospital Births (January 2014); (vii)Informed Choice (January 2014);(viii)The Ontario Midwifery Model of Care (January 2014); (ix) Inter professional Care •Delegation, Orders and Directives (January 2014);(x)Inter professional Collaboration (January 2014); (xi) Code of Ethics (1994);(xii)Practice Management;(xiii) Record Keeping Standard for Midwives (January 2013); (xiv)Essential Equipment, Supplies and Medication (July 2014); (xv) Practice Protocols (January 2015); (xvi) Practice Communication (July 2014); (xvii) Second Birth Attendants (In effect January 2015); (xviii) Clinical Practice; (xix) Ambulance Transport (January 2014); (xx) Blood Borne Pathogens (January 2014); (xxi) Caring For Related Persons (January 2014); (xxii) Clinical Education and Student Supervision (July 2014);(xxiii)Complementary and Alternative Medicine (January 2014);(xxiv)Consultation and Transfer of Care (January 2015); (xxv) Diagnostic Imaging (January 2014); (xxvi) Epidural Monitoring and Management (July 2014);(xxvii) External Cephalic Version (July 2014); (xxviii) Surgical Assistant in Obstetrics (July 2014); (xxix) Guidelines to Antepartum Consultations for Clients of Midwives to Anaesthesia (July 1996); (xxx) Induction and Augmentation of Labour (July 2014); (xxxi)Laboratory Testing (January 2014); (xxxii) Neonatal Resuscitation; (xxxiii) Newborn Eye Prophylaxis (January 2014); (xxxiv) Nitrous Oxide-Oxygen Blends (January 2014); (xxxv) Postpartum/Newborn Visits; (xxxvi) Prescribing and Administering Drugs (January 2014); (xxxvii) Routine Childhood Vaccinations (January 2014);(xxxviii)Twin and Breech Births (July 2014); (xxxix) Vaginal Birth After Cesarean Section and Choice of Birthplace (January 2014); (xl) When a Client Chooses Care Outside Midwifery Standards of Practice (January 2014).

- (b) The CMO requirements for six different practice protocols (care during pregnancy, care during labour and birth, care during postpartum, emergency situations, death and bereavement, conditions for safe practice) (2006)
- (c) Optional certification for midwives allowing them to act in the role of surgical first assist at caesarean section (2007)
- (d) Significant additions to drug list: These additions required practicing midwives to complete a learning module and to pass an exam prior to being able to prescribe these drugs as per the CMO. New drugs added were: Intravenous antibiotics for intrapartum prophylaxis for clients screening positive for vaginal/rectal Group B Streptococcus, oral antibiotics for the treatment of Urinary Tract Infections (UTIs) and asymptomatic bacteriuria, Mastitis and Bacterial Vaginosis; Non-steroidal anti-inflammatory (NSAIDs) drugs for the treatment of post-partum pain (Diclofenac, Naproxen); 2 additional antihemorrhagic and oxytocic drugs (Carbetocin, Misoprostol); two additional local anesthetics for perineal infiltration and repair (Bupivacaine, Chloroprocaine); Domperidone for milk supply issues; certain vaccines (Measles/Mumps/Rubella and Varicella Zoster Immune Globulin)(2009)
- (e) Take blood samples from fathers or donors for the purpose of tests that might impact the pregnancy. (2009)
- (f) Communicating a diagnosis identifying, as the cause of a woman's or newborn's symptoms, a disease or disorder that may be identified from the results of a laboratory or other test or investigation that a member is authorized to order or perform on a woman or a newborn during normal pregnancy, labour and delivery and for up to six weeks post-partum. (2009)
- (g) Putting an instrument, hand or finger beyond the anal verge (2009)
- (h) CMO Consultation and Transfer of Care Standard (2014) replaced the 1999 document "Mandatory Indications for Consultation and Transfer of Care". Midwives were no longer required to transfer care or perform a consultation with a physician for certain conditions and circumstances such as maternal age less than 14, pregnancy beyond 42 completed weeks' gestation, cephalhematoma in a newborn or a newborn with greater than 10% weight loss. These changes enable midwives to use their clinical judgment to determine when to consult or transfer care when a condition has not responded to midwifery intervention or therapy, increasing the responsibility of the midwife.
- (i) Introduction of the Quality Assurance Program 2015

- (j) Practice Assessment Workbook (PAW) (2015): Each year, the Quality Assurance Committee will randomly select three practice groups and will require all members of that practice who meet the following criteria to complete the PAW.
 - (k) Intubation of newborns beyond the larynx and umbilical vein catheterization of the newborn in the context of neonatal resuscitation (2015)
70. Midwives also have an ongoing obligation to ensure their midwifery practice is assessed and kept up to date.²¹

g. AOM Clinical Practice Guidelines

71. In addition to the above, the AOM developed Clinical Practice Guidelines (CPGs) starting in 1999. There had also been previous AOM guidelines to assist midwives in their practice.
72. These evidence-based CPGs are consistent with midwifery model of care, including informed choice, client as the primary decision-maker, choice of birthplace, and appropriate use of technology. AOM CPGs are developed using the "Values-Based Approach to CPG Development", a document that outlines the selection process for CPG topics, use of evidence, and development of recommendations.²²

h. Midwifery Pivotal to the Government's Health Reform Objectives and Providing High Quality Maternity and Newborn Care

73. The Government states that it seeks to have its compensation and funding policies reward those who contribute to and serve its primary health care reform objectives. Midwives have always been recognized as at the forefront of serving those objectives yet their contributions as a female dominated profession are not reflected in their compensation. These government reform objectives include the following:

21 See CMO Practice Assessment Workbook Policies and Procedures and CMO Practice Assessment Workbook (PAW), CMO Record-keeping Checklist and Chart Audit Tool and CMO Essential Equipment, Medications and Supplies Checklist and Audit Tool.

22 AOM Guidelines cover the following areas: No. 16: Group B Streptococcus: Postpartum Management of the Neonate (2014); No. 15: Hypertensive Disorders of Pregnancy (2012); No. 14: Vaginal Birth after Previous Low-segment Caesarean Section (2011); No. 13: Management of Prelabour Rupture of Membranes at Term (2010); No. 12: The Management of Women with a High or Low Body Mass Index (2010); No. 11: Group B Streptococcus: Prevention and Management in Labour (2010); No. 10: Management of the Uncomplicated Pregnancy Beyond 41+0 Weeks' Gestation (2010); CPGs still in use from 1999 to 2006: No. 9: Prevention and Management of Postpartum Hemorrhage; No. 8: Parvovirus B19 Infection in Pregnancy (rescinded 2015); No. 7: Screening for Gestational Diabetes; No. 2: Physical Assessment of the Well Woman; No. 1: Physical Assessment of the Newborn

- (a) The Excellent Care for All Act, (ECFAA)²³ principles aim to put Ontario patients first and recognize that "a high quality health care system is one that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focussed, and safe".
 - (b) Premier's mandate to Health Minister,²⁴ Patient's First: Action Plan for Health Care²⁵ and the Government's policy, "Transforming Ontario's Health Care System, Vision and Guiding Principles"²⁶ focus on leading the shift toward a sustainable, accountable system that provides co-ordinated quality care to people, when and where they need it and ensuring an equitable relationship amongst professions.
74. Currently the maternal and newborn health system in Ontario does not optimize, leverage or compensate midwives equitably as the experts in low-risk primary maternal and newborn care. Evidence-based standards and guidelines form the basis of midwifery practice in Ontario.²⁷
75. Quality and cost-effectiveness are the two driving forces behind health care transformation. Midwifery delivers both. This is frequently acknowledged in Government documents. See Appendix 5.
76. Given the high degree of congruence of midwifery care with Government reform objectives, it is evidence of their unequal treatment that this has not been translated into appropriate compensation whereas physicians have received significant increases without the evidence of the same high outcomes and reform congruency.
77. The following Ministry actions would facilitate the equitable integration and compensation of midwives:
- (i) increasing access to midwifery care (although about 80% of pregnancies are low-risk, midwives currently care for 14% while the bulk of low-risk care is provided by specialist OBs);
 - (ii) improving integration of midwives into hospitals (facilitate access to privileges and end restrictions to scope of practice that are not medically necessary);

²³ <http://health.gov.on.ca/en/pro/programs/ecfa/legislation/act.aspx>

²⁴ www.ontario.ca/page/2014-mandate-letter-health-and-long-term-care

²⁵ www.health.gov.on.ca/en/ms/ecfa/healthy_change/

26 "Transforming Ontario's Health Care System,
<http://www.health.gov.on.ca/en/pro/programs/transformation/transform.aspx>

²⁷ See "Outcomes of evidence-based midwifery care: An annotated bibliography" produced by the AOM.

- (iii) promoting out-of-hospital birth (home, clinic, birth centre); and
- (iv) ensuring health policy including compensation of providers like the midwives is driven by evidence (evidence-based care favours care practices that are effective and least invasive).

Part 3 The Claim for *Human Rights Code* Pay Equity

a. Systemic Gender Discrimination in Compensation Setting Practices

78. The AOM Application dated November 27, 2013 alleges that the MOHLTC compensation/fee setting mechanisms have since 1993 permitted, perpetuated and condoned systemic sex-based compensation for the complainant midwives and claims compensation and other remedial relief with respect to that discrimination as of January 1, 1997. The MOHLTC “contracts” which deliver that sex-based compensation are just one part of the system of the MOHLTC’s policies and practices which form the interwoven web of systemic gender discrimination which has, and continues, to result in the midwives receiving inequitable compensation for their work and services contrary to sections 3, 5, 9, 11 and 12 of the *Human Rights Code*.
79. Since the MOHLTC sets the remuneration of midwives, if there is any sex-based discrimination in that remuneration, it is the MOHTLC that has the responsibility for such discrimination, the obligation to prevent it from occurring, and the obligation to immediately rectify it where it has occurred.
80. The systemic gender discrimination in compensation which the AOM alleges is deeply rooted in an accumulation of societal, historical and ongoing prejudices relating to both midwifery work and women’s work, specifically and physician work, and MOHLTC institutional policies and practices which have devalued midwifery work because of, as stated in the Application a “gendered trifecta of: work by women, for women and as it relates to women's health.” This highly gendered context renders midwives particularly vulnerable to the Ministry, which determines both their compensation levels; and places limits on the compensation that they can earn and the process by which their pay is determined.
81. As recognized by the Tribunal in its September, 2014 Interim Decision, systemic gender discrimination is a unique form of discrimination. The Tribunal stated:

[31] In PSAC. Justice Evans discussed the particular nature of systemic gender-based wage discrimination, and how it must be understood through an examination of historical patterns (at paras. 117-118):

(....) the policy motivating the enactment of the principle of equal pay for work of equal value is the elimination from the workplace of sex-based wage discrimination. The kind of discrimination at issue here is systemic in nature: that is, it is the result of the application over time of wage policies and practices that

have tended either to ignore, or to undervalue work typically performed by women.

In order to understand the extent of such discrimination in a particular employment context it is important to be able to view as comprehensively as possible the pay practices and policies of the employer as they affect the wages of men and women.

b. The Connection to Women – The Gendered Trifecta

82. Midwives work in a “gendered trifecta” context.

- (a) Midwives are women. Over ninety-nine per cent (99.9%) of Ontario's registered midwives are women or transgender persons who can bear children. Since 2013, there has been one male midwife. There was also one male midwife between 1994 and 1997. It is the most exclusively female-dominated and sex segregated health care profession in Ontario.²⁸
- (b) As noted above, midwife means “with woman”. The College of Midwives of Ontario (CMO) Philosophy of Midwifery Care in Ontario states that midwifery health care “is continuous, personalized and non-authoritarian. It responds to a woman’s social, emotional and cultural as well as physical needs”. Midwifery places the needs of a woman, and her family, at the centre, including ensuring the woman in labour knows the midwife attending her birth.²⁹
- (c) Women’s organizations in Ontario were and are strong supporters of the midwifery model of care as part of the campaign for women’s rights to reproductive choices. This history and the unequal care received by women is highlighted in the 1987 Task Force Report on Midwifery and the AOM witness Vicki Van Wagner’s 1991 thesis: “With Women: Community Midwifery in Ontario” which was relied on in developing the regulated midwifery system in Ontario
- (d) Midwives provide specialized health care which is unique to the reproductive experience of women (and transgender persons). Midwifery continues to be a key part of the Government’s work in addressing women’s health care needs.³⁰

28 Health Professions Database 2010 Stat Book, Table 2- Regulated Health Professionals by Sex – 2010.

29 Source:
http://www.ontariomidwives.ca/images/uploads/newsletter/temp_file_fall_newsletter2013Web2.pdf

30 See Echo: Improving Women’s Health, which was an agency of the MOHLTC and its 2009-2012 report: Improving Women’s Health in Ontario, ECHO’s POWER Study; its Ontario Women’s Health Framework and the MOHLTC Health Equity Impact Assessment Workbook, Version 2,

83. The Ontario Cabinet in deciding to establish a midwifery education program highlighted this gendered context:

"Midwifery is a female dominated profession focusing on women's health care during pregnancy and childbirth. The philosophy of midwifery, as stated by the Interim Regulatory Council of Midwifery, recognizes a woman as the central decision maker for her and her infant's health care. The curriculum content for midwifery includes aspects, of women's studies so that childbirth is understood in the wider context of societal and cultural traditions and values.. Midwives can contribute to a less medicalized model of health care and help restore an emphasis on normal childbearing.

A program with flexible entry criteria, assessment of prior learning and decentralized clinical and other program' arrangements can facilitate women's entry to midwifery education and provide new career opportunities.. (Note: This does not exclude men from entering the profession, but recognizes the likelihood that women will predominate).³¹

84. As a result of a number of intersecting forces, (including feminist leadership in government at the time), strong consumer support from women and strong leadership from midwives, a relatively gender-sensitive analysis and process was used in the period from 1985 to 1994 to ensure that midwives arrived in the funded health care system in a relatively equitable position. The Government, as the compensation-setter of a historically disadvantaged almost exclusively female profession was able to reset the value of midwifery work to ensure it was roughly gender equitable as of 1993.
85. Yet you will see in the documentary evidence record of the Government and through the evidence of midwifery witnesses that the equity steps which were taken pre-regulation basically started to fall apart shortly thereafter. No mechanisms were put in place to provide an ongoing equity lens or gender based analysis in government midwifery decision-making and this included the lack of a pay equity monitoring process. The AOM's expert reports summarized in Appendix *3* to this Statement refer to the key importance of such gender based analysis. This analysis is missing from the MOHLTC expert reports.
86. The Task Force on the Implementation of Midwifery in Ontario (TFIMO) became the basis upon which the Government acted to establish a midwifery education system and to establish funding for the Ontario Midwifery Program and the compensation for midwifery services. While denied by the MOHLTC in its pleadings and expert reports, the TFIMO recognized the male dominance of the health care system and recommended a midwifery model of care which would

2012.

31 Cabinet Submission by the Ministry of Health and the Ministry of Colleges and University re: Midwifery Education in Ontario with Appendices, June 12, 1991

empower women and lead to a less medicalized birth experience for women. The Task Force also highlighted the positioning of the midwife between the nurse and the physician.

87. AOM experts also highlight the gendered way that physician dominance is embedded in the health care system, which is particularly problematic for midwives who are now trying to reassert their profession into the system.
88. Recognizing the connection of midwifery to women and women's health, the Government directed its Women's Health Bureau to initially shepherd the midwives through the process of regulation and funding.
89. Although a rough pay equity analysis ensured that midwives were equitably paid against a male dominated comparator the Community Health Centre physician when midwifery was publicly funded in 1994, pay equity has not been maintained over time. Midwifery compensation should be equitably set using an evaluation process that analyses skills, effort, responsibility and working conditions (SERW). Although the provincial wage gap ranges from 12% to 31.5%, midwives experience roughly a 48% gap based on current calculations which appear to underestimate the value of CHC physician compensation increases and benefit entitlements.³²

c. Pay Equity Act

90. Note: With respect to the *Pay Equity Act*, both parties agree that that *Act* does not govern the situation of the complainant midwives as the Government cannot be their employer pursuant to section 1.1 (1) of that *Act* which provides that, "for the purposes of this Act, the Crown is not the employer of a person unless the person (a) is a public servant employed under Part III of the Public Service of Ontario Act, 2006; or (b) is employed by a body prescribed in the regulations. 2006, c. 35, Sched. C, s. 107 (1). Midwives do not fall under either category.
91. Accordingly, the specific rules of the *Pay Equity Act* are not required to be applied although depending on the context they may provide some useful guidance. The MOHLTC and its experts often rigorously apply a provision of the *Pay Equity Act* where it is believed to advantage their position and then deny the application of the *Act* otherwise.

d. Summary of AOM Application

92. The following sets out a more detailed summary of the AOM Application and is taken directly from the AOM's November, 2013 Schedule A to the Application.

PART 1

SUMMARY OF APPLICATION

32 See Closing the Gender Wage Gap: A Consultation Paper for Businesses and Organizations, Ministry of Labour, October, 2015 at p. 7.

1. Inequitable Midwifery Compensation is Sex Discrimination

29. Since 1994, the SERWC associated with midwifery care have increased substantially without commensurate increases in their compensation and discriminatory pay equity gaps have arisen starting as of January 1, 1997. In fact, the Ministry, despite its 1993 agreement to provide annual cost of living increases to midwives, froze the compensation of midwives from 1994 to 2005 and thereafter provided inadequate increases relative to the value of the work and the compensation afforded to others.

30. In particular, substantial pay increases have been provided to the midwives' male comparator, the CHC physician, which were not proportionally provided to the midwives as required for pay equity purposes.

2. Expert Reports of Inequitable Compensation and Pay Equity Gaps

31. Pay equity and economist experts Paul Durber and Hugh Mackenzie in their reports filed with this application have identified the above-noted pay equity gaps. Durber carried out a systemic pay equity comparison of the work (SERW) and pay of Ontario's registered midwives since 1994 relative to the male-dominated CHC family physician and the CHC nurse practitioner. On the basis of his pay equity analysis, Durber found that sex bias was operating in the setting of the midwives' compensation by the Ministry. Taking into account Durber's pay equity analysis, Mackenzie analysed midwives' compensation over the period of 1994 to 2013, both in relation to the above-noted comparators and in relation to other economic contextual factors, such as the cost of living index during the period.

32. As a result of changes in the SERW of midwifery work since the 1993 Morton entry-level analysis, Durber identified pay equity adjustments required for Ontario midwives over the period from 1997 to present, to address the pay equity gaps. Hugh Mackenzie analyzed the actual monetary pay equity adjustments required as a result of the above-noted Durber analysis.

3. Violation of Midwives Right to Equal Treatment in Employment, Contracts and Association

36. The above-noted inequitable compensation violates midwives' human right to equal treatment in employment and is contrary to section 5 of the Code as it:

(a) delivers inequitable and significantly lower compensation to Ontario's midwives than their professional work is worth because they are women, they work for women, and because pregnancy and birth is a biological, genetic and gendered female experience. This discrimination is highlighted by fact that they are paid substantially less than comparable male-dominated work funded by the Ministry and government;

(b) *is substantially less than it should be as a result of the stereotypes, prejudice, systemic barriers and disadvantage that continue to cause a gendered "compensation penalty" or "discount" for midwifery work;*

(c) *is substantially less than it should be as a result of the Ministry's gendered and unequal bargaining and compensation practices that have favoured the male-dominated profession of physicians and denied midwives regular and fair negotiation processes;*

(d) *is substantially less due to the Ministry's failure to perform its stewardship role of planning for and establishing levels of funding in the health system that are free from sex-based discrimination.*

37. *Midwives' right to contract on equal terms pursuant to section 3 of the Code is also violated as this unequal compensation is embedded in the MOHLTC's contractual requirements governing the midwives.*

39. *Inequitable compensation for midwives is influenced by the fact that midwives are providing medical care to "women" and therefore have an "association, relationship or dealings" with persons who are identified by a prohibited ground of discrimination. As a result, this unequal treatment regarding compensation also violates section 12 of the Code.*

47. *As specifically recognized by the Pay Equity Act, Pay Equity Hearings Tribunal jurisprudence and academic research, it is likely that sex stereotyping and prejudice will pervade the evaluation and pay of jobs that are strongly identified with one sex or the other. Midwives are the occupation most highly identified with women since they are almost exclusively female and also work for women.*

52. *The inequitable compensation and benefits received by Ontario's midwives cannot be separated from the patterns of systemic gender discrimination that infuse the history of discrimination and prejudice against midwifery work in Ontario and the discrimination women have experienced in the health-care system. (See Part 2 – History of Discrimination Against Midwifery and Women's Health Care below.)*

e. What are the Unlawful Actions of the MOHLTC

93. Below paragraphs taken from AOM Application – Schedule A

4. Unlawful Actions of the MOHLTC

62. *In summary, the Ministry, aware of the historical systemic disadvantage and unequal treatment of the female profession of midwifery did not take the necessary proactive pay equity compliance steps post-1994 to ensure that midwifery compensation was free of sex-based discrimination. The Ministry also did not ensure such compensation, which it set on an ongoing basis, was not*

influenced by ongoing sex and gender-based stereotypes and prejudice that disadvantaged midwives and favoured the male-dominated profession of physicians and other male work. In this regard, the Ministry:

(a) failed to rigorously monitor changes in the work (SERW) of midwives and their compensation and their relevant comparators, particularly the work of the male-dominated CHC family physician.

(b) failed, in an ongoing way, to make visible and value the female work of midwifery. Although the Ministry stated it valued the work of the midwives, it failed to incorporate those statements of value into the compensation paid to midwives.

(c) devalued, when setting midwifery compensation, the evidence of the benefits of midwifery while favouring the value and worth of the work of the male-dominated profession of physicians. This occurred despite the fact that the OMP's objectives include ensuring an "equitable funding mechanism that supports the integration of midwifery services into the health care system" and the Ministry's Excellent Care for All Act stating that "health care providers will be paid based on how well they make quality their main job."

(d) ignored, despite policies that stipulate funding be "equitable and appropriate" and "consistent with the demand for and underlying value of the service," the high demand for midwifery services and the shortages of midwife providers and also failed to accord the appropriate compensation for the value of midwifery services that were consistently found to be of very high value and highly consistent with the objectives of the government's primary health-care reform.

(e) failed, despite midwives meeting all the Ministry's objectives for a reformed primary health-care system, to reward midwives appropriately while substantially rewarding the male-dominated profession of physicians over the relevant period.

(f) failed to incorporate a sex- and gender-based pay equity analysis into its compensation setting funding practices.

(g) failed to have mechanisms in place to support and protect the midwifery profession from ongoing systemic prejudice and discriminatory barriers faced as a result of being a new small female profession being integrated into the health-care system, where they provided care in a manner that challenged the status quo.

(h) refused to contract with midwives on equal terms by outright refusing to negotiate pay-equity compliant compensation levels with their bargaining agent, the AOM.

(i) *Refused to contract with midwives on equal terms by failing to have a negotiations process with the AOM in place to address required changes in compensation to ensure pay equity while at the same time engaging in negotiations with the Ontario Medical Association ("OMA"), the professional association of physicians, with respect to increasing their compensation and addressing changes in their work;*

(j) *failed to actively, promptly and diligently ensure the compensation system continued to provide pay equity for midwives by conducting an ongoing pay equity analysis that reflected the significant SERW changes to their work since the Morton analysis (based on entry-level competencies) took place, and failed to address the lack of pay equity for midwives;*

(k) *took advantage of the "caring dilemma" experienced by midwives and their professional requirements, i.e., midwives were conflicted about asserting their right to pay equity if it would impact the right of women to accessible and inclusive maternity and newborn care;*

(l) *failed to adequately investigate and properly respond to and address the complaints made by the AOM on behalf of its members since 1994 about the inequitable gendered compensation midwives were receiving as a result of the Ministry's actions and instead denied that midwives were entitled to any pay equity entitlements as they were independent contractors;*

(m) *failed to adequately respond to the 2003 and 2004 Hay Consultants reports on midwifery compensation and the Ministry's 2010 Courtyard Report, which it jointly commissioned with the AOM, all of which identified substantial pay equity gaps;*

(n) *failed to accord sufficient value to women's health care by failing to pay midwives, who provide care for the gendered experience of pregnancy and birth, compensation which reflects the value of their work;*

(o) *adopted an arbitrary and opportunistic approach by:*

(i) *treating midwives as being bound by compensation restraint laws while also arguing midwives were independent contractors and therefore not covered by the Pay Equity Act.*

(ii) *agreeing to negotiate with midwives when it suited the Ministry's agenda and declining to negotiate or refusing to characterize negotiations as such when it did not, though at all times it characterized such OMA interactions as "negotiations."*

(p) *failed to exempt from restraint laws and policies required to ensure midwifery compensation is free of sex-based discrimination even though such laws and policies provided an exemption for adjustments required to comply with the Pay Equity Act or the Human Rights Code. This had an adverse effect on*

midwives who performed women's work since they were frozen at compensation levels that were not pay equity compliant;

(q) failed to engage in any appropriate pay equity/human rights analysis with the AOM or otherwise so as to carry out appropriately its proactive Human Rights Code obligations;

(r) permitted the midwives' pay equity gap to widen substantially over nearly 20 years, while at the same time arguing it is too costly to close it because the gap is so large.

Part 4 Issues to Be Addressed in this Application

94. Adjudicating this Application requires the Tribunal to consider relevant evidence and considerations to address the following issues:
- (a) Are the complainant midwives members of a protected group under the Code?
 - (b) Have the complainants experienced an adverse impact in relation to their compensation and funding;
 - (c) Is there a "connection" between the protected characteristic of the sex of the midwives and this adverse impact.
 - (d) In case of systemic discrimination, this means showing that practices, attitudes, policies, procedures, patterns, actions or inactions impacted disproportionately on midwives as a protected group.
95. For reasons detailed in Part 14 of this Statement below, the AOM submits that it has already established a prima face case of discrimination based on agreed and not disputed facts.
96. Accordingly, the AOM submits that the focus of the hearing should be on the MOHLTC showing that it has non-discriminatory reasons for its conduct which are not related in any way to the sex of the midwives.

Part 5 The Short Story of How Midwives Came to Suffer from Systemic Gender Pay Discrimination – Got Rough Pay Equity Justice and then were left to Suffer from Unequal Treatment and Pay Discrimination Again

97. Female midwives until towards the end of the 19th century provided almost all maternity care services in Ontario. However, that changed as government laws made midwifery "alegal" and male physicians later supported by nurses took over the maternity care system. The reasons for this exclusion are rooted in gender discrimination as set out in the Task Force on the Implementation of Midwifery in Ontario which contains a detailed Appendix setting out this history of midwifery. This Task Force history details the extensive efforts of the male dominated

medical profession to exclude and marginalize midwifery and to propagate myths and prejudices about the unsafe nature of midwifery work and the value of physician led maternity care. Versions of these prejudices and stereotypes continue to operation in some measure in Ontario and devalue the work and pay of midwives. .

98. This history is highlighted as contextual background in the AOM expert reports of Mr. Durber, Dr. Armstrong and Dr. Bourgeault. With the exception of Candace Johnson's report, the MOHLTC expert reports and MOHLTC pleadings and witness statements ignore this gendered history of midwifery disadvantage and pay discrimination.
99. In the 1970's, female midwives working in communities and women concerned with the medicalization of birth started to organize and advocate for the return of midwifery to the maternity care system.
100. In 1985 the Ontario government took steps to equitably integrate the almost exclusively female midwifery profession into its funded and regulated health care system. The history of Midwifery's re-emergence, the campaign for integration and the negative attitudes and prejudices faced by midwives as nearly exclusively female profession is set out in Part V of the AOM Overview Summary of Evidence by AOM Witnesses attached as Appendix 2.
101. Over the period from 1985 to 1995, the Government worked with the AOM and midwifery leadership through its 1987 Task Force, the leadership of the Women's Health Bureau, the Interim Regulatory Council on Midwifery, the Curriculum Design Committee, and the Community Health Branch.
102. Starting with the TFIMO and continuing with the reports of the Interim Regulatory Council of Midwifery, the Ministry's view was that the midwifery compensation should be greater than the CHC senior primary care nurse/nurse practitioner and lower than the CHC physician in light of the midwife's 24/7 on call responsibilities, her role as an autonomous primary health care provider and the extent of shared scope of practice.
103. As it became time to determine the funding mechanism in 1993, there had still not been a decision as to the employment structure for midwives with options still being considered of having midwives as employees in CHC's, birth centres or hospitals or being contractors in midwifery practice groups.
104. With the shared focus of midwives and Community Health Centres as community based managed health services, the AOM MOHLTC Joint Midwifery Funding Group working with Robert Morton stated by the Government at the time to be a "compensation specialist" focused primarily on comparisons with the CHC physician and CHC senior primary care nurse/nurse practitioner.
105. This was at the same time as the *Pay Equity Act* was being amended to provide for two additional methods of comparison, proportional and the proxy comparison

method. The Community Health Centres were using the proxy comparison method to achieve and maintain pay equity under the *Pay Equity Act* and the MOHLTC was providing pay equity funding to those CHCs for required adjustments.

106. As a result, using a rough pay equity job evaluation analysis based on skill, effort, responsibility and working conditions, the AOM and MOHLTC through the joint committee process compared the midwifery work (then based on 1992 midwifery entry level competencies) with the CHC Physician (then a general practitioner) and senior primary care nurse/nurse practitioner. The pay range was set at higher than the senior primary care nurse/nurse practitioner and lower than the CHC physician.
107. At the time of this 1993 evaluation, general practitioners or family physicians in Ontario overall were 71% male. Ontario Physicians generally were 75.3% male. The historical incumbency of the CHC physician is clearly male. At the time when CHC physicians were first hired in CHCs around 1978, and the MOH first set their compensation, Ontario family physicians were 88.1% male and Ontario physicians generally were 88.1%.³³ The data shows that such professions have become less male dominated since 1993. However, there is still stereotyping about the physician field of work as being associated with men.
108. This process was the Government's "measuring stick" or pay equity mechanism for considering whether the pay of the female dominated profession of midwives was gender equitable in the funded health care hierarchy. Setting up an equitable relationship between the midwife and the CHC physician and nurse practitioner was also a way to ensure that, depending on changes in work, the pay of midwife continued to be in the proper proportional relationship.
109. At that time, midwifery pay – ranging in 12 steps from \$55,000 to \$77,000, based on this rough analysis was about 90% of the start rate of the CHC physician working in a fully serviced area. The analysis was based on midwifery entry level competencies. This analysis was carried out at a time when all Cabinet submissions were required to have a gender impact analysis in order to be considered by Cabinet and that was true for the midwifery cabinet submissions.
110. The consensus of the AOM and the MOHLTC working in the Joint Midwifery Work Group was reflected in the September 1993, Ontario Midwifery Program Framework document. This document has since repeatedly been referred to by Government decision-making documents as the foundation of the Ontario Midwifery Program. See Appendix 2 Part XI of the AOM Overview Summary of Evidence of AOM Witnesses for a review of the initial setting of the midwifery funding and compensation.

33 Canadian Institute for Health Information (CIHI) Physician Counts, Number of Physicians by specialty and gender and percentage distribution by gender, Ontario and Canada, 1978 to 2014, custom tabulation. .

111. The complainant midwives had their employment structured by the MOHLTC initially as salaried "dependent contractors" and then in 2000 on devolution to local transfer payment agencies their employment was deliberately structured by the MOHLTC as independent contractors in order to protect the model of care and to protect their professional role as autonomous health care providers. As noted above, the midwifery model of care and 24/7 on call work was not consistent with the *Employment Standards Act* rules for employment and hours. That decision was based on the care needs of the client not the provider. However, the MOHLTC continued for *Code* purposes to be "dependent" as MOH has considerable control over their work and pay as the Ontario Midwifery Program is a 'managed' program.
112. Ontario midwives are in a position of control/dependency which renders them vulnerable to discrimination. Such vulnerability is exacerbated by their status as:
 - a) the most exclusively female health care profession in Ontario and b) a profession which has been subjected to historical disadvantage and prejudice as pleaded in the Application.
113. The MOHLTC's control of midwifery work and working conditions, includes the following:
 - a) To work in the funded health care system as a midwife in Ontario, it is necessary to work in a MOHLTC funded midwifery clinic. There is no other market for regulated midwifery services other than as part of the Ontario Midwifery program;
 - b) Midwives are unable to open funded midwifery clinics without prior approval by the Ministry and midwives are unable to open clinics in the location of their choice without prior MOHLTC approval;
 - c) A midwife wishing to open a midwifery clinic must complete a New Practice Proposal (the template of which is set by the Ministry) and submit it to the Ontario Midwifery Program, which decides whether to accept proposals on an annual basis; and
 - d) MOHLTC controls:
 - a. the services area or catchment area that a midwifery clinic is permitted to serve (see Schedule B of the 2013/14 TPA-MPG contract);
 - b. the number of midwives that can practice in that catchment area and in each clinic;
 - c. the number of clients the midwives of any given clinic are permitted to provide care for (see Schedules E and F); and

- d. the type and volume of equipment the clinic is permitted to purchase (see pp 54 – 56 of the TPA-MPG agreement).
 - e. midwives and midwifery practice groups must submit comprehensive data and reports to the Ministry in order to be paid.
114. While it may be appropriate to structure midwifery services as an independent contractor relationship to ensure the midwifery continuity of care model, which can involve 24 hours of continuing care to a pregnant woman, that structure should not be used to provide an inferior set of equality rights to midwives.
 115. Following the 1993 setting of compensation, midwifery pay was frozen for 11 years with just a few increases given thereafter. The MOHLTC acknowledges that it has not done any work or pay equity or human rights analysis of the skill, effort, responsibility or working conditions of midwives (SERW) since then.
 116. Over the period since 1994, midwifery pay fell way behind as detailed in the AOM expert report of Hugh Mackenzie cited below.
 117. These complainants, through their Association, have made extensive and protracted efforts for nearly 20 years to get the MOHLTC to provide them with gender equitable compensation for the valuable “women's work” they do. While women are not supposed to have to fight for pay equity as noted by the Ontario’s Chief Commissioner of the Ontario Human Rights Commission, that is exactly what they have had to do here.
 118. During the devolution discussions in late 1990's, the AOM's 1998 Principles of Funding document provided to the MOHLTC required that "midwives will work within a payment model governed by policies which are consistent and equitable across the province". At the time, midwives focused on ensuring that the new contractor model of compensation did not result in any reduction of their pay.
 119. After the devolution discussions were finished in 2000, the AOM wrote the CHB requesting equitable compensation back to 1994, noting there had been no COLA adjustments and including a cost of living analysis.
 120. When the Government was initially not responsive in 2001, the complainants paid through their dues for the retainer of Hay Associates to do a compensation review in 2003 (updated in 2004) which called for substantial compensation and funding increases and endorsed the measuring stick of comparing to the CHC physician and nurses. (In contrast, the Government paid for the 1999 CHC Hay Compensation reviews which it commissioned with the Association of Health Care Centres to assess CHC compensation) The Government never specifically responded to the AOM’s Hay report appropriately and only took action to negotiate some increased midwifery compensation in December, 2004 after the frustrated midwives had mounted a "Storks Don't Deliver Babies" campaign and were going to have a public demonstration attended by the media.

121. The midwives received some compensation adjustment at that time, but were told to wait for equity as the Government could not afford to make up for the years of frozen compensation. Recent Government document disclosures highlighted in Appendix *5* to this Statement show that the Community Health and Promotion Branch was busy at the same time going to considerable lengths to ensure that CHC physicians were provided with "equitable compensation" and "aligned" relative to other primary health care physicians as part of the Ministry's Primary Health Care Renewal Strategy.³⁴
122. While MOHLTC experts state that it is not appropriate to compare and align the midwifery contractor compensation arrangement with a salaried CHC physician, in part because they are different systems of compensation, the MOHLTC did just that when it signed an agreement with the OMA effective as of 2003 to align the salaried CHC physicians with other primary care fee for service physicians as part of its Primary Health Care Renewal Strategy. This resulted in significant compensation adjustments, a signing bonus and incentive payments and other benefits.
123. Even though Government documents show that midwives were also clearly a key part of that Strategy, the Ministry did not engage in a similar analysis to align them equitably in the Primary Health Care Provider compensation hierarchy. The MOHLTC as of 2004 started to negotiate CHC Physician compensation with the male dominated Ontario Medical Association.
124. In the absence of any established equity framework and gender based analysis in this MOHLTC decision-making, the midwives were denied pay equity and compensation free of sex discrimination. The Government continued to put any available monies towards expansion of the program and payment of the increased professional liability insurance premium expenses. At the same time, the Government expanded the CHC program with many new centres yet still substantially increased CHC physician compensation as well. Midwives were not given the benefit of such a comparative "alignment" process.
125. After that, the Government still refused to do a proper work and pay analysis of midwifery work and only after further lobbying and campaign efforts and another Hay analysis in 2007, did the Government agree as part of the 2009 contract to undertake a joint compensation review. The Government delayed in carrying out that review which was not undertaken by the Government-retained Courtyard consultants until July – September, 2010. The review was to inform the contract negotiations which were to start by September 30, 2010.
126. When the Courtyard Report called for a 20% one-time equity adjustment and confirmed that the positioning of the midwife in relation to the CHC physician and Nurse Practitioner remained appropriate, the MOHLTC decided that the joint

34 See Appendix 5, Section XVI

review it had closely participated in was flawed and would not be followed. Government documents show that a further review was not appropriate as it would likely also arrive at a substantial equity adjustment as well.³⁵

127. As well at the time of this Courtyard process the Ministry was implementing its agreement to move the Government was implementing its agreement through the 2008-2012 OMA agreement to review the CHC physicians' compensation and return it to a salary basis. Unlike the Courtyard review, this review was acted on by the MOHLTC and resulted in a substantial increase in compensation for the CHC physicians at a time when the midwives were to be told as noted below that their compensation had to be restrained.
128. The Government decided then to apply compensation restraints covering only "employees" under the *Public Sector Compensation Restraints Act, 2010* to freeze the midwives' pay while denying it had any obligation to provide pay equity to midwives as they were independent contractors and not covered by the *Pay Equity Act*.
129. MOHLTC conceded that midwives were not technically covered by this restraint legislation but in the spirit of the legislation, MOHLTC would be applying this restraint to midwives. The restraint legislation makes an exception for cases of pay equity adjustments. The AOM requested that MOHLTC abide by the spirit of restraint legislation and make an exception for midwives who were seeking a pay equity adjustment to their compensation. MOHLTC responded that pay equity legislation did not apply to midwives, and therefore, they refused to apply the spirit of this part of the restraint legislation, or the spirit of the pay equity legislation, to midwives.
130. The MOHLTC insisted for many years that the AOM forego or delay its requests for increases in compensation to address equity issues and provided the AOM with a series of reasons for those requests which are detailed in the AOM Application and in the supporting documents filed by the AOM. These reasons included the following:
 - (a) During the period 2000 to the current time, the reason was the Government budget did not provide funds for compensation increases.
 - (b) From 2010 onwards the Government's demand that midwifery compensation including any equity adjustments had to be restrained. See Application, 281-283, and paras. 307-383. During the period prior to 2000, the MOHLTC refused to consider any increase in compensation. See paras. 184-195 of the Application.

35 See Appendix 5, Section XVI

- (c) In 2003, Minister of Health Tony Clement speaking to an AOM conference stated that he would get to midwives once he had completed negotiations with the nurses;
 - (d) Between 2000 and 2005, MOHLTC continued to assert lack of available funds prevented adjustments but stated it was still committed to fair compensation. Minister Smitherman in 2005 requested that the AOM give the MOHLTC time to address its compensation concerns as it could not address them all in the 2006 contract. See paras. 198-242 of Application.
 - (e) MOHLTC delayed initiating negotiations from April 2008 (which they had agreed to initiate in a signed MOU) to October 2008 due to internal restructuring, during which time the economic crisis occurred and then there "was no money", despite the fact they completed a robust contract with the OMA announced in late summer, 2008 - a contract which led to a review and increase in CHC physician funding.
 - (f) For period from 2008 onwards, MOHLTC deferred addressing the issue as well until it saw the results of the jointly commissioned Courtyard report.
 - (g) Once that report was issued in September 2010, MOHLTC again deferred consideration until it had had chance to study and consider the report while also stating that the Report was no longer relevant as the Government was now bound by the compensation restraint policy.
 - (h) In September, 2011, Premier McGuinty responded to AOM communication about equitable compensation by stating he believed midwives should be fairly compensated for what they do. Application para. 325.
 - (i) The MOHLTC asserted that the AOM must use an internal MCFAC process in order to address issues with respect to the "compensation" but now asserts that the AOM should have filed the Code complaint many years ago.
 - (j) The AOM pursued MOHLTC's designated "internal" avenues for securing pay equity compliant compensation. The AOM bargained in good faith trusting that the MOHLTC would adhere to the commitments made to look at fair compensation. At the same time the Ministry addressed the concerns of the OMA on behalf of male dominated physicians and greatly increased the compensation of the CHC physicians.
131. After the AOM had tried many different ways to engage the MOHLTC in changing its compensation practices, it gradually became apparent that there was a systemic deeply rooted problem which meant that MOHLTC compensation practices favoured work associated with male privilege and medical dominance over women's work – with women who care for women being treated unequally within the health care compensation system.

132. Finally, when all efforts to get the government to reconsider its position failed, the Complainants instructed the AOM to bring this HRTO proceeding and retained Mr. Durber to carry out the measuring stick pay equity human rights analysis which should have been done and paid for by the Government way back in 1996 and onwards.
133. Ultimately, the full implications of the extent of the gender pay gap caused by the MOHLTC compensation practices and policies were not apparent until it was revealed in the November, 2013 Durber report which made the analysis and comparisons with the CHC physician and nurse practitioner work which the Ministry should have been doing all along. The AOM application was filed on November 27, 2013.
134. As noted above, systemic gender discrimination is complex with the implications and interaction of institutional and societal practices, policies and prejudices often hidden and subtle. That is why there is a pro-active obligation on those responsible for compensation to make visible and value women's work. This is an obligation holders responsibility – not a protected group's responsibility.
135. The Durber report using the New Zealand Equitable Compensation system and based on extensive documentation and contextual gender based analysis, found that the MOHLTC pay for midwifery did not provide for compensation free of discrimination. Durber found that the pay as of 2012 should be 91% of the CHC physician. Durber also evaluated changes in the work and pay of the midwives since 1993 and documented pay gaps over those years as a results of the increasing SERW of the midwives and the increasing pay of the CHC physicians. See Appendix "3" for highlights of this report and a summary of its findings.
136. In contrast to the lack of any equity or job evaluation analysis by the MOHLTC, the Durber report provided an extensive and documented pay equity/human rights analysis.
137. Regardless of the way women's work is structured, there is a need to examine such work and pay to see whether systemic gender discrimination in compensation is operating. This requires using some form of evidence-based analysis as a measuring stick to analyze whether the compensation to be decided upon is free of sex-based gender discrimination. Such a measuring mechanism is particularly necessary where the female profession at issue has suffered exclusion and disadvantages and endured stereotypes and prejudices. Details of these disadvantages, stereotypes and prejudices are set out in the Task Force in Implementation of Midwifery in Ontario and in the expert reports of Mr. Durber, Dr. Armstrong and Dr. Bourgeault.

Part 6 The MOHLTC Response to the Claim – Deny, Ignore Systemic Claims and Focus on Durber Report rather than MOHLTC Systemic Actions

138. The MOHLTC unabashedly takes the position that it does not consider “sex” or “gender” when it sets compensation or develops compensation setting practices. Yet that is just the point of the obligation to carry out a sex/gender based analysis or lens. This admission is one of the key facts which supports the AOM claim of discrimination. Without any special equity mechanisms in place to monitor the pay and work of midwives to see if it is free of discrimination, women's pay, even if established relatively equitably, quickly became inequitable.
139. The MOHLTC has yet to address in its pleadings, expert evidence or witness statements its response to the “unique” systemic form of discrimination which is being claimed by the Applicant. It has not addressed or responded to the need to understand the nature of systemic gender-based wage discrimination, as Justice Evans stated in PSAC “through an examination of historical patterns (at paras. 117-118). In fact, the MOHLTC takes the position that such historical patterns were irrelevant.
140. Once the application was filed in November, 2013, the Complainants continued to be frustrated by the MOHLTC's denial of its claims and failure to engage genuinely with the AOM on addressing the serious issues raised by its Application.
141. Once again, instead of analyzing its own actions, the MOHLTC first moved to strike out the midwives' claims prior to November 27, 2012 because of delay and the expiring of contracts setting out compensation it had determined, and then hired experts to critique and challenge the AOM's compensation review report filed by Mr. Durber, the former head of the Canadian Human Rights Commission's Pay Equity Unit. The Government has stubbornly held on to its position that it does not have to do anything until a Tribunal should order it to do so.
142. The MOHLTC has gone to great lengths to deny that it ever conducted any pay analysis when it set the compensation of midwives in 1993. It appears that denial was necessary in order to be able to then continue to deny that it had to continue such a pay equity analysis. However, documentation produced by the MOHLTC to the AOM as result of its production requests shows that the 1993 Joint Work Group was engaged in a form of a pay equity analysis. This document, which is titled “Primary Position Comparisons: Introduction/Rationale, Preliminary Draft For Discussion Purposes Only” describes the factors of skill, effort, responsibility and working conditions in the following manner:

The general factors used for analysis are those specified in legislation (i.e. the Pay Equity Act); that is, skill, effort, responsibility and working conditions. They are considered an industry standard in many countries and were recently used

by the Ontario Government to determine pay equity across all job classes in the Ontario Public Service.

143. The Government now says that it did not conduct any version of a pay equity analysis back in 1993 and has adopted its expert reports which state that the July 1993 Morton report and joint committee process was fundamentally flawed in any event. Further the government states it is not required at any time to conduct any pay equity/human rights analysis to see whether there is systemic gender discrimination operating in the pay of midwifery work as the midwives are not covered by the *Pay Equity Act* and the *Human Rights Code* does not compel it to act proactively to monitor and evaluate the work.
144. The MOHLTC has in hindsight characterized through its experts reports that the Morton report was fundamentally flawed. However, the witness and documentary evidence is clear that the Government in adopting the September 1993 Ontario Midwifery Program Framework relied on the consensus developed by the AOM and the MOHLTC with the assistance of Mr. Morton. AOM witness Jane Kilthei who lead the AOM team in the Joint Working Group will testify that the parties were engaged in a pay equity exercise. The documents forwarded to the AOM membership in October, 1993 to ratify the September 1993 Program Framework characterize the Working Group process as a "pay equity exercise". See Overview Summary of AOM Witness Evidence, Appendix 2.
145. The Government's pleadings and witness statements do not describe the way midwifery compensation has been set since 1994 nor how it set the compensation of CHC physicians and other comparators.
146. Instead, the Government has filed expert reports in which its experts speculate or estimate what the substantial difference in compensation between the CHC physician and the midwife is caused by – e.g. difference in education, scope of practice, authorized acts and number of clients. There is no systematic analysis of the work of the midwife or the work of the CHC Physician and Nurse Practitioner.
147. It appears these experts were never provided with the Government documentation now provided to the Applicant which actually showed the basis for government compensation decision-making in relation to the midwives and the CHC physicians and other comparators.
148. Accordingly, much of the MOHLTC expert reports are therefore irrelevant as they appear to be the opinions of experts about possible rationales for the acknowledged substantial difference in compensation unrelated to the actual facts underlying the MOHLTC compensation setting decision-making.
149. As well, the Ministry since this Application was filed now denies that it "negotiates" with the AOM because it is not a "bargaining agent" under the *Labour Relations Act* but only "consults" with the AOM concerning the

compensation and funding which it states it establishes. This is not consistent with government documentation produced by the MOHLTC spread over nearly 20 years.

150. The Tribunal's examination needs to start with reviewing the systems, actions, inactions, policies and practices which led to the compensation results for midwives and their comparators. None of the MOHTLC experts reports do that. The MOHLTC witness statements also do not provide much assistance either.

Part 7 MOHLTC Midwifery Compensation Setting

a. Midwifery Compensation Embedded in Contracts and Policies

151. The Ministry, through contractual directives and policies, including the Transfer Payment Agency ("TPA") template agreement, sets the compensation of Ontario's registered midwives.³⁶ Currently, these directives and policies are contained in the contracts between the Ministry and approximately 18 local TPAs as well as between those TPAs and the midwifery practice groups. At the time of regulation in 1994, these directives and policies were contained in the contracts between the Ministry and the Lebel Midwifery Care Organization and the practice groups. These contracts included:
- (a) the LMCO Funding Agreement (1994-1999) relating to compensation, operating, special operating and non-recurring expense;
 - (b) the 2000 Devolution Funding Agreement which set up midwives as independent contractors and provided for billable courses of care, caseload variables, disbursements, and grants;
 - (c) the 2005 Funding Agreement which increased the fees for billable courses of care, reduced the experience levels from 12 - 6, and included an experience fee, on call fee and operational fee and in some cases a retention fee and secondary care fee and also included provisions for disbursements and grants;
 - (d) the 2008 Funding Agreement which provided for fees, including an experience fee, on call fee, operational fee and in some case included a retention incentive and a secondary fee. It also introduced the following supplements for small rural or remote practices, including an experience fee and an operational fee supplement. An MOU between the AOM and MOHLTC also included a provision for caseload variables and disbursements as well as introducing a parental leave program and included grants.

36 Template Funding Agreement between Transfer Payment Agency and the Midwifery Practice Group, 2013 – MOHLTC Version.

- (e) The 2011 and Subsequent Fee Schedule extensions did not provide for any increase in compensation.
152. The expert reports of Paul Durber and Hugh Mackenzie set out in detail how the midwifery gender pay gap was determined and calculated. See Appendix ** – Summary of AOM Expert Evidence. The Durber report finds that the midwife's work using a gender neutral comparison system analyzing skill, effort, responsibility and working conditions should be valued at 91% of the CHC Physician's work.
153. Despite provision in the 1993 Program Framework for cost of living adjustments the Ministry has never provided midwives with any cost of living adjustments. On regulation, the MOHLTC subjected the midwifery compensation to deductions under the *Social Contract Act* from 1994 to 1996 and froze the compensation of midwives from 1994 to 2005.
154. Thereafter the MOHLTC provided inadequate or no adjustments to ensure that the compensation afforded to midwifery as an almost exclusively female profession reflected the value of the work. Such lack of appropriate adjustments failed to recognize the increasing value of the work over the years since 1994, particularly as reflected in the Paul Durber expert report filed in this proceeding, including the above-noted increasing scope of practice; increasing complexity of work; and the administrative and practice demands placed on midwives by the Ministry's policies, practices and contractual term; and the strong clinical outcomes of midwifery work.
155. Substantial pay increases have been provided by the MOHLTC to the midwives' comparator, the CHC physician, which were not proportionally provided to the midwives in a way which reflected the proportionate value of their work.

Part 8 MOHLTC CHC Physician Compensation Setting

a. Community Health Centres

156. Community Health Centres are inter-professional primary care non-profit organizations that combine clinical health promotion and community development services with a focus on the social determinants of health. They are governed by community-elected boards and funded by the MOHLTC. All staff are salaried including physicians and nurse practitioners. During the 1980's many senior primary care nurses in the CHCs came to be known as nurse practitioners for the extended responsibilities of their practice.
157. As of 2012, Ontario CHCs employed 394 primary care physicians, 322 nurse practitioners and large numbers of other clinical, health promotion, community development, administrative and management personnel. CHC physicians carry out their medical care in a collaborative model with Nurse Practitioners, nurses, and many other health care personnel including social workers, counsellors,

lactation consultants and therapists. Many patients are only seen by a Nurse Practitioner.

158. AOM Witness Teresa Agnew, a nurse practitioner and head of the Nurse Practitioners Association of Ontario and previously a long time CHC employee. will speak to this model. The MOHTLC CHC physician witness statements make no reference to this model and the role of these professionals in providing care in their statements. As noted below, many CHC patients are seen by a doctor but only by a nurse practitioner. Many of the care tasks which these physicians refer to in their statements can also be provided by these other professionals.
159. Community Health Centres provide maternity care to low risk women through a shared physician/nurse model assisted where often by other CHC health professionals. In some CHCs, it is the Nurse Practitioner who provides the prenatal and post-partum care. CHC family physicians with some exceptions, do not provide intrapartum care.(although Mr. Durber, in an abundance of caution, credited them with doing so). CHC pregnant clients with a low risk profile are referred to obstetricians at 28 weeks and to midwives at earlier date in the pregnancy. High risk patients would be referred at an earlier date to obstetricians.
160. Unlike midwives, CHC physicians do not have the significant administrative and management responsibilities of midwives. CHCs have a professional and administrative support infrastructure to carry out those responsibilities for them.
161. The province's CHC program expanded rapidly in the late 1980's. New funding halted in 1995/96 but resumed in 2002 following a 2001 strategic review of the CHC system.³⁷ Since 2004, the MOHLTC has vastly expanded the budget for CHCs not only because of the increase in physician compensation but also because they have opened more than 20 new Centres, growing from 54 to 73 with many having satellite offices.³⁸ Most of these locations are situated in the same local areas as midwifery catchment areas and many of the underserved areas for CHCs which merit the higher physician compensation grid are also underserved areas where midwives practice. Between 2007 and 2011 CHC funding was devolved to the Local Health Integration Networks (LHINs).

b. CHC Physician Compensation

162. The Ministry has set the compensation of Ontario CHC physicians since they were first established in the 1970's. Prior to that time, the Ministry set the compensation of CHC physicians through the setting of approved provincial salary ranges for the CHC staff including the "Physician" and the "Nurse I and

37 See Dr. Chandrakant P. Shah and Dr. Brent w. Moloughney, "A Strategic Review of the Community Health Centre Program", May 2001 for a detailed review of this Program and the work of CHC physicians and nurse practitioners.

38 See list of Community Health Centre locations, MOHLTC, <http://www.health.gov.on.ca/en/common/system/services/chc/locations.aspx>.

Nurse II.”³⁹ These salary ranges were detailed in the Ministry's 1991 CHC Compensation Review. These salary ranges are set out in the Morton report.

163. The CHC physician compensation was frozen by the MOHLTC until effective 2003 when the physicians started to receive large increases in compensation and benefits. This was in stark contrast to the treatment by the MOHLTC of midwifery compensation. For a review of the CHC physician compensation increases over the years, see the 2000 CHC Hay pay equity report, the 2004 AOM Hay report, and the 2007 Hay analysis for the AOM.
164. Since 2004, the salary of CHC physicians is the only CHC salary which is negotiated through the Physician Services Agreement between the MOHLTC and the Ontario Medical Association (OMA) and whose funding is designated and protected, separate from global funding provided for the rest of the CHC positions.⁴⁰
165. The data regarding CHC physician compensation available to the applicant's experts thus far has only accounted for Base Salary (funding intended to cover delivery of services in core and extended hour blocks), benefits and on-call fees.
166. However, through disclosure it has become apparent that from 2004 to 2010 CHC physicians were also eligible for Salary Linked Adjustments (SLA) and Comprehensive Care Management Fees (CCM). SLA is used to refer to the amount paid in lieu of incentives and bonuses paid to primary care physicians that are not available to the CHC. These include after-hours premium, new and unattached patient fees, chronic disease management fees, special payments (e.g. serious mental illness), and preventative care management fees.⁴¹ During this period in the CHC model, the CCM fee per physician depended on the average number of enrolled patients for all physicians (all patients enrolled by CHC physicians were pooled).⁴² However, for a majority of the relevant period the MOHLTC did not have access to actual data and relied on estimates in order to make CCM and SLA payments.

³⁹ The Nurse II designation was for the Senior Primary Care Nurse also sometimes referred to as a Nurse Practitioner, although the formal standard for the Nurse Practitioner did not take place until 1998 when the Expanded Nursing Services for Patients Act was passed. “This legislation gave NPs registered in the extended class with the College of Nurses of Ontario (initially primary health care NPs) the authority to practice within a broader scope of practice which included three additional controlled acts: communicating a diagnosis, prescribing a limited range of drugs, and ordering certain tests, x-rays and ultrasound” However, the use of the name was not a protected title until 2008” (from the Nurse Practitioners History in Ontario, <http://npao.org/nurse-practitioners/history/>)

40 “Community Health Centres in Ontario” Accreditation Canada, [www. Accredation.ca](http://www.Accredation.ca), prepared by the Primary Health Care Branch, Negotiations and Accountability Management Division, MOHLTC

41 Exploring Options for Aligning CHC Compensation with CHC Service Profile (July 2009) [MOH004418](#) at p 2

42 Exploring Options for Aligning CHC Compensation with CHC Service Profile (July 2009) [MOH004418](#) at p 2

i. Blended Salary: The OMA's Efforts to establish compensation equity between primary care physicians

167. Through representation by the OMA, CHC physicians were able to bring their concerns to the negotiation of the 2004- 2008 Physician Service Agreement. Internal documents indicate that by 2004 the MOHLTC had committed to prioritize equitable compensation amongst physicians. The document *Community Health Division Workload Priorities* includes as a priority to: "work with Primary Health care and Physician Policy Branch, Assoc. of Ont. Health Centres, the OMA, and the CHC Business Affairs Group to determine an equitable compensation formula for CHC physicians."⁴³
168. Details of this "equitable compensation formula" were then set out in Appendix E of the 2004 Physician Services Framework Agreement ("PSA") which identified CHCs as a non-capitated Harmonized Patient Enrolment Model (PEM).⁴⁴ Rather than be paid solely salary the Harmonized Model (PEM) meant that CHC physicians became eligible for the following incentive and bonus payments in addition to their salaries: ⁴⁵
1. FFS Flow through Physician Compensation Adjustments
 2. Comprehensive Care Capitation and Primary Care Physician Incentives and Bonuses
 3. Continuing Medical Education payments
 4. Per patient rostering fee
169. During this period the Ministry also made significant infrastructure investments in CHCs, including a \$1.6 million dollar grant for upgraded medical equipment in CHCs in March 2005.⁴⁶ These were not regarded as part of the physician's total compensation.

ii. Coping with Uncertain Data: Interim Payments

170. According to the Hay report, in 2004 physicians in CHCs which were not designated underserviced had a salary range of \$113, 259 to \$136, 450 while those in CHCs which were Northern/designated underserviced had a range of \$ 143 573 to \$172, 967. The salary ranges sent from the OMP to Courtyard set out the following salaries from 2005 – 2007:⁴⁷

year	Not designated	Northern/designated
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43 Community Health Division Workload Priorities (December 2004) MOH015855 at CHC Program #4

44 CHC Update on Physician Compensation, by PHC Executive (2010-03-16) OMT0002934

45 Overview Harmonization of Community Health Centres (2009-05-15) OMT0001505

46 Letter from MOH to CHC re. funding for equipment (March 2005) OMT0001057

47 CHC Salary Scales Sent from OMP to Courtyard AOM0005070 (email attaching: AOM0005069)

	underserved	underserved
2005	\$117, 668.88 to 141, 762.50	\$149, 163.15 to 179, 702.01
2006	\$120, 351 to 144, 995	\$152, 564 to 183, 799
2007	\$122, 264 to 147, 299	\$154, 989 to 186, 720

171. However, these figures do not account for the additional bonuses introduced as a result of OMA bargaining.
172. Due to the unique structure of CHCs the MOHLTC did not have data available to pay incentives based on actual services provided. However, shortly after agreeing to the new model of payment to MOHLTC identified an urgent need to begin increasing CHC compensation. An internal committee recommended retroactive salary linked adjustments noting that "CHC physicians are months and in some cases years behind their colleagues practicing in other primary care setting in their ability to generate incentive income. This is already contributing to growing recruitment and retention issues, particularly for urban CHCs."⁴⁸ In May 2007 the Primary and Community Care Committee (PCCC) approved interim and retroactive incentive payments to be made to CHC physicians"⁴⁹ These retroactive payments Retroactive Payments accounted for:⁵⁰
- Interim payment for Comprehensive Care Management (CCM) based on predicted achievement of 60% of enrollable clients
 - Additional payment of \$2340/FTE related to projected pooled value of incentive and bonus claims (differential between \$7000 owed and previous payment of \$46601FTE)
173. From 2005 until 2010 these adjustments were paid regularly to CHC physicians in addition to their base salaries. In information provided the CHC's the MOHLTC reiterated its goal of creating equity with other primary care physicians, stating that "the Ministry is harmonizing compensation for CHC physicians with that of physicians in other aligned models of primary health care."⁵¹
174. Based on the documentation which has been produced to the applicant to date, it is difficult to calculate the exact rise in compensation to CHC physicians during

48 Implementing the Primary Care Incentives in the 2004-08 Agreement between MOHLTC and OMA (est 2005)

49 Letter from MOH to London CHC re physician interim and retroactive payments (January 2008) OMT0001300

50 MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups - Summary (2008-01-01) OMT0001290

51 Letter from G.Smitherman to G. Stein (President, South-East Ottawa Community Services) re: Harmonized Compensation for CHC Physicians (Nov 2005) OMT0001056

this period. It is clear that payments for physician incentives and bonuses were made in December 2005,⁵² June 2006,⁵³ April 2007 and March 2008.⁵⁴ For all interim and retroactive payments to all CHC physicians during this period the amounts were based on an estimate of the actual earnings that would be verified once information systems work had been completed.⁵⁵ These Interim Payments were calculated on the assumption of anticipated achievement of 60% of enrollable clients for Comprehensive Care Management (CCM) and f \$7000/FTE for projected pooled value of incentive and bonus claims⁵⁶ These funds were protected, to be used only for funding physician salary, such that CHCs were asked to return surplus not spent on physician funding.⁵⁷

175. In order to be able to verify these estimates and begin paying bonuses based on actual service, CHCs were asked to roster patients to CHC physicians and to collect various necessary information regarding service provision.

iii. Controversy Caused by Rostering

176. The requirement that CHC's roster patients to the physicians caused a degree of controversy . Two letters written to the Ministry by Nurse Practitioners in the winter of 2007 illustrate these issues. In March 2007 Nurse Practitioner A. Mawji wrote the following to then Minister Smitherman:

"In the past two years our physician partners have had a 21-33% salary increase. This is due in large part to the OMA's successful negotiations with the MOH

...

We are currently in the process of rostering all CHC patient to physicians. What I found astounding is that many of these patients have never seen a physician; many of these patients are my patients. This rostering is facilitate proposed "billing" for preventive care

...

as a Primary Health Care Provider who has chosen to work in a CHC because of the philosophy of care, I find it appalling that MD's will be billing for services that are considered to be part of quality Primary Health Care. I find it equally appalling

52 Overview Harmonization of Community Health Centres (2009-05-15) OMT0001505

53 Overview Harmonization of Community Health Centres (2009-05-15) OMT0001505

54 MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups – Summary (2008-01-01) OMT0001290

55 MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups – Summary (2008-01-01) OMT0001290

56 MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups - Summary (2008-01-01) OMT0001290

57 Memo from J. Barber (Manager, CHC Program) to D. Hole (Executive Director, South-East Ottawa Community Services) re: Salary Surpluses (Jan 2007) OMT0001187

*that MD's will be billing for services and paid for services that RNECs also do but do not get recognition or pay for"*⁵⁸

177. In February of 2007 the Co-Chair of the Ontario Alliance of Practitioners for Equity wrote to outline similar concerns:

*I am writing to you regarding the impending implementation of physician rostering and billing for preventive care at CHCs throughout Ontario... Many of my patients have seldom or never seen a physician. Rostering of patients to my physician partners will undermine my authority and autonomy. My patient should be rostered to their Primary Provider.*⁵⁹

178. Although the MOHLTC did not discontinue the direction to roster CHC patients, it was aware of these issues. An internal MOHLTC memo from 2009 notes that "the physicians are receiving the incentive and bonus payments for the work of NPs"⁶⁰

iv. The 2008 Physician Services Agreement

179. At the time that the 2008 PSA was being negotiated the MOHLTC did not yet have the data necessary to verify estimates that had been used to calculate incentive payments in the blended salary model. Rather than revisit the payment model, section 5.13 of the 2008 Physician Services Agreement mandated the creation of the Physician-LHIN Tripartite Committee (PLTC) to review options for compensating CHC physicians.
180. In early 2008 it was determined that physicians would continue to receive interim payments for salary-linked incentives until information systems were in place to process incentive claims based on actual experience"⁶¹ As of 2008 the base salary of CHC physicians in CHCs Not designated underserved was \$124, 460 to 149, 945 and in underserved CHCs was \$157, 772 to 190, 074.⁶² In 2009 the base salary was 140, 434.55 to \$157, 142.02 for not underserved CHCs and \$165, 345.56 to \$199, 197.52 for underserved CHCs.⁶³

58 Letter from A. Mawji (Nurse Practitioner) to G. Smitherman and NPAO/RNAO re: Nurse Practitioner Salaries (2007-03-27) OMT0001207

59 Letter from L. Hales (Co-Chair, Ontario Alliance of Practitioners for Equity) to Dr. Rachlis re: Physician Rostering and Billing for Preventative Care at CHCs attaching Fact Sheet (Feb 14 2007) OMT0001193

60 Overview Harmonization of Community Health Centres (2009-05-15) OMT0001505

61 Q & A Update - January 2008 - Questions and Answers on Physician Payments, Group Registration, Enrolment/THAS and Primary Care Incentives (2008-01-01) OMT0001295 at question 34

62 Exploring Options for Aligning CHC Compensation with CHC Service Profile (July 2009) [MOH004418](#)

63 Report to Physician-LHIN Tripartite Committee CHC Physician Compensation Working Group MOH004509 at table 1

v. Collapse of the blended salary model

181. The goal of the MOHLTC was for incentive payments to be based on actual patient enrolment after April 1, 2009.⁶⁴ However, from the documents available it appears that in the fall of 2008 the MOHLTC discovered errors in the estimates that had been used to predict bonuses. The estimates had been overly optimistic, resulting in overpayments in the previous years.⁶⁵ A 2008 internal slide deck notes that CHCs physicians had been unable to meet the predicted patient numbers for which they had been paid.⁶⁶

vi. Introduction of a full salary model

182. In January of 2010 the Physician LHIN Tripartate Committee (PLTC) decided that CHC physicians would move a fully salaried compensation model effective April 1, 2010.⁶⁷ The new salary ranges were based on CHC physician FTE base salaries and an estimate of CHC physician FTE annual incentives and bonuses.⁶⁸ In other words, incentives that were previously to be earned through individual physician billing activities through OHIP will be rolled into the base salary of CHC physicians⁶⁹

183. As set out in the chart below, the committee opted to include a wide range of bonuses. This created a significant increase in compensation given that CHC physicians had been unable to meet the corresponding rostering goals and that the MOHLTC in fact had recognized that much of the work was being done by other members of the CHC team.

184. Although the respondent is in the best position to identify the exact value of compensation received by the CHC physicians during these periods the increase in base salary was significant.

Compensation at time of review (March 2010)⁷⁰		
Payment Element	Communities not designated underserved	Designated under serviced
Base salary	\$130, 436 - \$157, 142	\$165, 346 - \$199, 198
BSM-SLA Payment	\$31, 657	\$31, 657
CCM Fee	\$25, 238	\$25, 238

64 CHC Payments for the Comprehensive Care Capitation (CCM), Incentives, and Bonuses (2008-09-15) OMT0001391

65 Email from Sophie Zikmanis to Irene Medcof re Clarification on Physician Payments (2008-09-22) OMT0001393

66 MOH Slide Deck re Update on Status of Payments for Comprehensive Care Capitation (CCM), Incentives and Bonuses (2008-10-29) OMT0001404

67 CHC Update on Physician Compensation, by PHC Executive (2010-03-16) OMT0002934

68 CHC Update on Physician Compensation, by PHC Executive (2010-03-16) OMT0002934; Letter from MOH to Champlain LHIN re physician compensation increase (May 2010) OMT0001579

69 Letter from LHIN to CHC re physician compensation changing to salaried model (July 2010) OMT0001594

70 CHC Update on Physician Compensation, by PHC Executive (2010-03-16) OMT0002934

+ blended FFS	\$2, 819	\$2, 819
+ special premiums	\$1, 533	\$1, 533
+ preventative care management	\$213	\$213
+ after hours premiums	\$449	\$449
+ New Patient Fees	\$1, 075	\$1, 075
+ Chronic Disease Management	\$333	\$333
BSM Non-SLA Payment	\$6, 764	\$6, 764
CME	\$1, 200	\$1, 200
+ Rurality Gradient	\$1, 089	\$1, 089
+ Special Premiums	\$1, 900	\$1, 900
+ Rostering fee	\$1	\$1
+Preventative Care Bonuses	\$2, 574	\$2, 574
Total New CHC Salary (Base + SLA + Non-SLA)	\$168, 856 - \$195, 563	\$203, 767 - \$237, 619
Total New CHC Salary (25% Benefits & Relief)	\$209, 464 - \$234, 849	\$245, 103 - \$287, 418

Part 9 Ontario's Health and Maternity Care System – Sex/Gender of Professions

185. In looking at the evidence as it is put forward, it is necessary to place it in the context of Ontario's gendered and sex segregated health and maternity care system which has physicians in privileged position at the top of the compensation and power hierarchy. The history of the male dominance of the medical profession and gendered context of the health care system is reflected in the findings of the Task Force on the Implementation of Midwifery in Ontario, the expert reports of Mr. Durber, Dr. Armstrong and Dr. Bourgeault and the statements in Government documents referred to in Appendix "5".⁷¹

a. The Health Care System and Medical Dominance

186. Ontario's health care system provides health care services in a variety of different ways through many different health care providers. Insured services are provided not only by "fee for service" physicians but also by health care providers who are salaried or are paid on a contractual basis.

187. There is a hierarchical structure within the health care system with physicians as the dominant profession. Midwives experienced both before and since regulation that physicians exercise the most power amongst the health care professionals, particularly as it relates to their control of access to hospital privileges and the

71 See OMP Hospital Integration Surveys, 2009 and 2011.

restrictions on their scope of practice in hospitals. For example, physicians and dentists were the only “privileged” care providers until midwives got admission and discharge privileges in 1994. As well, the attempts to expand the Medical Advisory Committee structures enshrined in the *Public Hospitals Act* to include midwives has been unsuccessful.

188. Both midwives and nurse practitioners provide high-quality and cost-effective primary care in areas that have traditionally been the domain of physicians. Their distinct knowledge and care is on an equal footing with physicians in many respects and in a number of aspects produce better outcomes. As well, some skills such as providing medical care at a home/out of hospital birth are unique to midwives.

b. Sex/Gender of Health Care Professions

189. Dr. Armstrong and Dr. Bourgeault will testify to the highly gendered nature of Ontario’s health care professions, with women dominating lower paying work and physicians dominating the higher paying work.
190. While there are increasing numbers of women physicians generally and in Community Health Centres, the physician profession is still male-dominated and continues to exist in a model originally established by and for men.
191. The male domination of physicians overall is particularly highlighted in the decision-making structure of its representative organization, the Ontario Medical Association, which historically has had few women in leadership positions.
192. The OMA is the entity the Ministry bargains with for Ontario physicians including CHC physicians. When the AOM meets with the OMA, the OMA representatives are predominantly male. The composition of the OMA Board and Executive and Chair of OMA council up to 1992 were 100% male. Over 20 years later, there has not been a significant change in the male predominance of its leadership, despite the increasing numbers of female physicians: In 2013, 5 out of 6 members of the Executive were men, (approx. 83%) and 17 out of 19 members of the Board of Directors (89.5%) were men.⁷²
193. Nurses in Ontario are highly female-dominated with 94.8% female in 2011. The extended class of nursing, the nurse practitioner, is 95% female predominant.⁷³

72 See Chart OMA Leadership Gender Breakdown with a sampling of years and the names and sexes of the members. Source: Issues of the Ontario Medical Review.

73 Canadian Nurses Association, “2010 Workforce Profile of Nurse Practitioners in Canada”, November 2012 accessed at <http://www.cna.aic.ca/~media/cna/page%20content/pdf%20en/2013/07/26/11/07/2010_np_profiles_e.pdf>

Part 10 HRTO Interim Decision

194. The HRTO Interim Decision in this proceeding provides importance directions for the Tribunal on considerations for assessing the evidence in support of the AOM's Application and the MOHLTC Response and the expert evidence.

a. Introduction

195. As a result of a motion by the MOHLTC to dismiss AOM allegations prior to one year before the November, 2013 application, Executive Chair Gottheil issued a decision which made the following findings binding on the parties in this matter.

- (a) The AOM Application covering extensive allegations over a nearly 20 year period is timely as a claim of systemic gender discrimination in compensation.⁷⁴
- (b) The AOM and the hundreds of complainants are entitled to have their application "understood, considered, analyzed and decided in a complete, sophisticated and comprehensive way".⁷⁵ The Tribunal ruled against the MOHLTC's "compartmentalized view of the claim" which focused on the making and expiry of "contracts" over the years since 1994.⁷⁶
- (c) The importance of a purposive approach to *Code* compliance ensuring access to those who seek its protection:

"human rights legislation must be given fair, large and liberal meaning and read in a purposive way which will best achieve its objects. It is also important to remember that the principle of a purposive approach relates both to the goals of achieving substantive equality and eliminating discrimination as well as to reading the Code in a manner that ensures access to those who seek its protection".⁷⁷

b. Systemic Gender Discrimination in Compensation under the *Code*

196. The Tribunal's Interim Decision also provided the following guidance about how the claim of systemic gender discrimination in compensation under the *Human Rights Code* in this matter should be addressed:

[29] The nature of systemic gender-based discrimination is in some respects unique as a form of discrimination, and has been recognized as such in academic literature, reports and jurisprudence. See, for example, Abella, Rosalie

74 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii).

75 *Ibid*, para. 33

76 *Ibid*, para. 33

77 *Ibid*, para. 35.

S., *Report of the Commission on Equality in Employment*. Ottawa: Minister of Supply and Services Canada, 1984; Ontario Human Rights Commission, *Policy and Guidelines on Racism and Racial Discrimination*, www.ohrc.on.ca; *CN v. Canada (Canadian Human Rights Commission)* 1987 CanLII 109 (SCC), [1987] 1 S.C.R. 1114 ("Action Travail des Femmes"); *Public Service Alliance of Canada v. Canada (Treasury Board)* 1999 CanLII 9380 (FC), [1999] F.C.J. No. 1531 ("PSAC"); *Grange v. Toronto (City)*, 2014 HRTO 633 (CanLII).

[30] In *Action Travail des Femmes*, the Supreme Court of Canada adopted the concept of systemic discrimination as developed in the Abella report. At pp. 1138-9, the Court stated:

A thorough study of "systemic discrimination" in Canada is to be found in the Abella Report on equality in employment. The terms of reference of the Royal Commission instructed it "to inquire into the most efficient, effective and equitable means of promoting employment opportunities, eliminating systemic discrimination and assisting individuals to compete for employment opportunities on an equal basis." (Order in Council P.C. 1983-1924 of 24 June 1983). Although Judge Abella chose not to offer a precise definition of systemic discrimination, the essentials may be gleaned from the following comments, found at p. 2 of the Abella Report:

Discrimination ... means practices or attitudes that have, whether by design or impact, the effect of limiting an Individual's or a group's right to the opportunities generally available because of attributed rather than actual characteristics ...

It is not a question of whether this discrimination is motivated by an intentional desire to obstruct someone's potential, or whether it is the accidental by-product of innocently motivated practices or systems. If the barrier is affecting certain groups in a disproportionate/y negative way, it is a signal that the practices that lead to this adverse impact may be discriminatory.

This is why it is important to look at the results of a system

In other words, systemic discrimination in an employment context is discrimination that results from the simple operation of established procedures of recruitment, hiring and promotion, none of which is necessarily designed to promote discrimination. The discrimination is then reinforced by the very exclusion of the disadvantaged group because the exclusion fosters the belief, both within and outside the group, that the exclusion is the result of "natural" forces, for example, that women "just can't do the job" (see the Abella Report, pp.9-10).

[31] In PSAC. Justice Evans discussed the particular nature of systemic gender-based wage discrimination, and how it must be understood through an examination of historical patterns (at paras. 117-118):

(...) the policy motivating the enactment of the principle of equal pay for work of equal value is the elimination from the workplace of sex-based wage discrimination. The kind of discrimination at issue here is systemic in nature: that is, it is the result of the application over time of wage policies and practices that have tended either to ignore, or to undervalue work typically performed by women.

In order to understand the extent of such discrimination in a particular employment context it is important to be able to view as comprehensively as possible the pay practices and policies of the employer as they affect the wages of men and women. (emphasis added)

[32] This perspective was also affirmed in *Public Service Alliance of Canada v. Canada (Department of National Defence)*, 1996 CanLII 4067 (FCA), [1996] 3 F. C. 789 ("PSAC/DND"):

Systemic discrimination is a continuing phenomenon which has its roots deep in history and in societal attitudes. It cannot be isolated to a single action or statement. By its very nature, it extends over time.

[33] Systemic claims are about the operation and impact of policies, practices and systems over time, often a long period of time. They will necessarily involve an examination of the interrelationships between actions (or inaction), attitudes and established organizational structures. A human rights application alleging gender-based systemic discrimination cannot be understood or assessed through a compartmentalized view of the claim. Whether or not the applicant will be able to establish a violation of the Code remains to be seen. However, the applicant has filed an Application on behalf of over 500 individuals, particularized it in detail, and provided a clear theory) that links the events to a claim of gender-based systemic discrimination. The applicant is entitled to have its claim understood, considered, analyzed and decided in a complete, sophisticated and comprehensive way.

197. The Tribunal has found that the AOM application sets out a

"detailed narrative of events, clearly connected in terms of subject, parties and time, articulated the theme which runs through the entire claims and has supported the allegation of systemic discrimination with two expert reports. It is hard to imagine an application that provides more detail of context, alleged patterns of conduct, common circumstances and underlying them than the present Application." Para. 41

c. The Obligation under the *Code* to Prevent Discrimination

198. The Tribunal decision cited Supreme Court of Canada jurisprudence which imposes on those responsible to providing equality to protected groups an obligation to prevent discrimination and not just to react to discrimination once proven to have occurred:

Citing the decision of the Supreme Court of Canada in *Action Travail des Femmes*⁷⁸

*"... I recognize that in the construction of such legislation the words of the Act must be given their plain meaning, but it is equally important that the rights enunciated be given their full recognition and effect. We should not search for ways and means to minimize those rights and to enfeeble their proper impact.The purposes of the Act would appear to be patently obvious, in light of the powerful language of s. 2. In order to promote the goal of equal opportunity for each individual to achieve "the life that he or she is able and wishes to have", the Act seeks to **prevent all "discriminatory practices" based, inter alia, on sex.** (at pp. 1133-34, (emphasis added)*

See also Ontario Human Rights Commission v. Simpsons-Sears Ltd., 1985 CanLII 18 (SCC), [1985] 2 S.C.R. 536 ("O'Malley"), at pp.546-47.

199. This citing of the Supreme Court of Canada's ruling that human rights laws "seek to prevent all "discriminatory practices, based inter alia on sex" is critical to the focus in human rights jurisprudence on imposing obligations on those with equality obligations, like the Government here to protect women, the racialized, those with disabilities and all other Code covered groups from having to experience discrimination. Such jurisprudence is directly at odds with the Government position here that it can wait to see after a long hearing whether the midwives have proved that Ministry conduct constitutes sex discrimination before acting.
200. As with disability discrimination, this means that women have an independent procedural right to a mechanism which will analyze whether their work is pay equity compliant and this right is independent of whether pay discrimination can be proved. The pay equity comparison process is a human right in and of itself. See *Fair v. Wentworth School Board*, Ontario Court of Appeal, 2016.

d. Case about Systems and Practices Not Just Contracts

201. The Tribunal in the interim decision rejected the MOHLTC argument that the case was only about 'unfair contracts' which were expired.

78 Ibid, para. 35

[27] Also, as noted earlier, the applicant seeks relief extending beyond remuneration for the alleged inequitable compensation structure and rates. It seeks a declaration of a Code violation, damages for injury to dignity and self-respect, as well as an order for future compliance, to ensure that the alleged discriminatory policies and practices, inequitable compensation, and injury does not reoccur. These remedies are significant aspects of the Application, and are not properly recognized by characterizing the claim as simply a complaint about compensation for a series of unfair contracts.

[28] In addition, viewing the claim in the way advanced by the respondent ignores the systemic dimension of the Application. The claim of systemic, gender-based discrimination is central to the Application, and therefore to a complete and proper analysis of its merits.

202. The Tribunal's interim decision emphasized the need to take a broad and comprehensive lens when viewing the actions of the MOHLTC

[37] Alleged incidents, along with particulars of historical practices, policies and attitudes, must be viewed comprehensively and in aggregate. It is this interwoven amalgam of conduct, actions, inaction, policies, practices, systems and attitudes which is alleged to result in differential treatment and discriminatory impact. The connections between incidents may not always be obvious and may not be purely linear or continuous. But together, the Interconnected web is what constitutes the series of incidents.

203. The Tribunal's Interim Decision also held that systemic gender discrimination in compensation is a recognized phenomenon at the time of the Code reforms.

[52] The Code does not define the word "series." In my view, there is no reason to place a meaning on the word that would require, in all cases, regardless of context, a linear, continuous connection between all allegations. There is no basis for presuming the Legislature intended such an approach when it enacted section 34(1)(b). Quite the opposite; the concept of a "series of incidents" as comprising the whole of a claim is entirely consistent with the Legislature recognizing the unique nature of systemic discrimination (as well as other types of human rights claims), and that it intended that such claims could be brought and adjudicated in their full and proper context.

[53] At the time the amendments were introduced the concept of systemic discrimination was well-established and understood. Also, the Pay Equity Act was passed in 1987 to redress systemic issues of gender discrimination in compensation of employees in female job classes. In this light, it seems clear that the words "series of incidents" in section 34(1)(b) are capable of encompassing applications such as the one before me (and arguably specifically intended to do so). There may be a series of incidents, events, practices, that extend over a long period of time, which together form the claim of systemic

discrimination. And that claim can be advanced, and will be considered timely, so long as it is brought within one year of the latest incident.

204. In the context of systemic discrimination, it is the obligation holders under the *Code* who are responsible for monitoring their institutional structures, policies and practices and their impacts on protected groups. Since the cumulative effect of such “incidents” is what causes systemic discrimination, obligation holders must be held accountable and this is what the Interim Decision ruled.

Part 11 Other Legal Obligations Relevant to Considering the Evidence and Deciding this Application and the Government’s Response

205. This application claims that the respondent Ministry has violated the *Human Rights Code* and in particular sections 3, 5, 9, 11 and 12 flowing from its setting of an inequitable compensation structure for Ontario’s midwives

206. The key legal provisions, principles and jurisprudence relied upon by the applicant include the following:

a. Section 5 - Right to Equal Treatment With Respect to Employment and Pay Without Discrimination Based on Sex

207. Section 5 of the *Code* provides that:

Every person has a right to equal treatment with respect to employment without discrimination because of... sex...

208. The allegations made here relate to employment discrimination and the allegation that the pay provided for work and services is sex-based.

209. The Tribunal's Interim Decision reviewed above has already addressed this issue in finding that systemic discrimination in compensation is covered by the *Code*.

210. Sex-based pay or compensation discrimination has been found to be a violation of the right to equal treatment in employment under human rights laws. The existence of the separate *Pay Equity Act* does not take away from the quasi-constitutional obligations under the Human Rights Code to ensure that women do not receive unequal treatment with respect to compensation.⁷⁹ The right to be free from sex-based discrimination in compensation or pay equity is a fundamental human right guaranteed by the *Human Rights Code* and the *Pay Equity Act*.⁸⁰

79 *Nishimura v. Ontario (Human Rights)* [S.C. Ont. 11 C.H.R.R. D/246, *Reid v. Truro (Town)* 2009 NSHRC 2, *Canada Safeway Limited v. Saskatchewan (Human Rights Commission)* (1999) 34 CHRR D/409 and *CUPE v. Local 1999 v. Lakeridge Health Corp.* 2012 O.J. No. 2451.

80 *Campe v. Borland Canada*, 2010 HRTO 1257 and *Morin v Brink's Canada Limited*, 1995 Canlii 879, *Sacco v. John Howard Society of Peel Halton Dufferin* 2012 1185 and 2251.

211. As noted by Mr. Justice Evans in the 1999 Federal Court decision in *Public Service Alliance of Canada v. Treasury Board*, [1999] F.C.J. No. 1531 a human rights tribunal must take a broad and liberal approach to its statutory mandate to eliminate systemic gender discrimination in compensation between male and female work. (para. 122) See also decision of Pay Equity Hearings Tribunal in *ONA v. Haldimand Norfolk* (1991), 2 P.E.R. 105 which also called for such an interpretation.
212. There are two major Ontario laws which ensure that women's work is paid free from sex-based discrimination – Ontario's *Pay Equity Act* ("PEA") and the *Human Rights Code* – the two laws which the MOHLTC has stated are its "internal human rights policies" relevant to this application.
213. While historically, the *Pay Equity Act* has been the major focus of pay equity enforcement, increasingly Ontario women are also looking to the *Human Rights Code* for pay equity enforcement.
214. The recognition of these dual paths for enforcement is reflected both in Pay Equity Hearings Tribunal and HRTO jurisprudence and also in Divisional Court rulings.⁸¹
215. The *Pay Equity Act* preamble sets out the recognition by the Ontario Legislature that there is "systemic gender discrimination in compensation" in Ontario experienced by those doing women's work which in context of the *Pay Equity Act* are the female job classes in employer establishments.
216. Accordingly, it is recognized in Ontario law that "it is desirable that affirmative action be taken to redress gender discrimination in the compensation of employees employed in female job classes in Ontario." See Preamble, *Pay Equity Act*. While this law does not apply directly to Ontario midwives, it reflects the public policy in Ontario that gender discrimination in the compensation of work by female-dominated professions should be redressed through affirmative measures.
217. The *Code* is no less a powerful instrument than the *Pay Equity Act* for redressing systemic gender discrimination in compensation. In fact, the AOM submits it is more powerful as it has no restrictions or limitations and acts to address all aspects of the actions of the MOHLTC which contribute to systemic gender discrimination. This means that it provides for broader remedial orders to address systemic factors which are contributing to the systemic gender discrimination in compensation.

⁸¹ See *Canadian Union of Public Employees Local 1999 v. Lakeridge Health Corporation*, 2012 ONSC 2051 and *Nishimura v. Ontario (Human Rights Commission)* 1989 CanLII 4317 (ON SC), (1989), 70 O.R. (2d) 347 (Ont. Div. Ct.).

218. The Code and PEA are complementary equality mechanisms which implement the Legislature's goal of redressing systemic gender discrimination in the compensation of women's work in Ontario.
219. As stated by Nova Scotia Human Rights Tribunal in *Reid et al. v. Town of Truro 2009, NSHRC-2*, "common sense dictates" that complaints of women of a violation of their right to equal pay for work of equal value" in relation to men "come under the umbrella of section 5(1)(d)(m) of the Act which provides no discrimination in employment on grounds of "sex". (see paras. 7 and 92) The Supreme Court of Canada in *Newfoundland (Attorney General) v. N.A.P.E., [1988] 2 SCR 204* also clearly concluded that systemic gender discrimination in compensation is sex-based discrimination contrary to the equality provisions in section 15(1) of the *Canadian Charter of Rights and Freedoms*.
220. It is well-established that systemic gender discrimination in compensation is caused by an amalgam of institutional practices, policies, and societal and institutional prejudices which disadvantage women. As stated by the Pay Equity Hearings Tribunal in *ONA v. Haldimand Norfolk (No.6)* (1991), 2 P.E.R. 105 at para. 9

It is increasingly acknowledged that the persistence of systemic wage discrimination acts as a barrier to the full and equal participation of women in the workforce. The Supreme Court of Canada in Janzen v. Platy Enterprises Limited cited with approval from Bell v. Ladas [(1980), 1 C.H.R.R. D/155 at D/156] in addressing related issues of sexual harassment and pay discrimination:

The evil to be remedied is the utilization of economic power or authority so as to restrict a woman's guaranteed and equal access to the workplace and all of its benefits ... Where a woman's equal access is denied or when terms or conditions differ when compared to male employees, the woman is being discriminated against. [19891.S.C.Rrul. 1252 at 1277]

One such benefit is fair wages. A fair wage is important to the well-being of workers, not only in meeting the necessities of life, but in guaranteeing a sense of dignity and of recognition for the value of the work they perform. This has relevance in the context of pay equity. The Act requires Employers to remedy pay discrimination by identifying and redressing the wage gap through a pay equity plan. Where the Employer's employees are unionized, these obligations must be undertaken in conjunction with the bargaining agent.

at para. 10

The Pay Equity Act, 1987 acknowledges that wage discrimination in women's salaries has been systemic. The Act does not seek to lay blame upon employers or unions for historical wage discrimination, but rather provides a framework for redressing that wage discrimination. Thus,

motive and intent are unhelpful in assessing whether these parties have met their obligations under the Act; the goal is not to punish wrongdoers but rather to provide an effective remedy for wage discrimination. [See Re: Ontario Human Rights Commission v. Simpson Sears Ltd., [1985] 2 S. C. R. at p.547, see also Action Travail des Femmes v. C. N. R. Co., [1987] 1 S. C. R. 1114]

In dealing with the issue under the *Canadian Human Rights Act*, Mr. Justice Evans in the *Public Service Alliance of Canada v. Treasury Board* decision referred to systemic discrimination in compensation as:

...systemic wage differences between men and women performing work of equal value, differences that are attributable in part to historic patterns of job segregation. (para. 95)

221. The 1992 decision of the Canadian Human Rights Tribunal in *Public Services Alliance of Canada v. Treasury Board*, File T.D.491 dated March 19, 1991 highlights this as follows:

*The concept of systemic discrimination, on the other hand, emphasizes the most subtle forms of discrimination, as indicated by the judgement of Dickson, C.J. in CN v. Canada (Human Rights Commission), [1987] 1 S.C.R. 1114, at 1138-9. It recognizes that long-standing social and cultural mores carry within them value assumptions that contribute to discrimination in ways that are substantially or entirely hidden and unconscious. **Thus, the historical experience which has tended to undervalue the work of women may be perpetuated through assumptions that certain types of work historically performed by women are inherently less valuable than certain types of work historically performed by men.** (Emphasis added)*

222. Mr. Justice Evans in *Public Service Alliance of Canada v. Canada (Treasury Board)* also highlighted this important aspect of dealing with systemic discrimination claims:

130 The concept of systemic discrimination, the mischief at which section 11 is primarily aimed, can be difficult to grasp. As this case clearly shows, the elucidation and application of the principle of equal pay for work of equal value calls for the kind of multi-disciplinary study in which the Tribunal engaged.

223. The failure to ensure women's work is paid proportionately equally on the basis of skill, effort, responsibility and working conditions with men's work is also a violation of the right to equal pay for work of equal value guaranteed by ILO Convention 100 and the right to non-discrimination in employment and occupation set out in ILO Convention 111.

224. In addition to the approach of comparing female work to specific male comparators in order to identify gender discrimination in compensation, such discrimination can also be identified by determining whether the compensation

for an occupation or industry is lower than it would have been because of gender considerations. This includes looking at the feminized nature of the work performed, e.g. caring work.⁸²

b. The Obligation to be Pro-Active and Prevent Discrimination

225. The Supreme Court in *McCormick v. Fasken Martineau Dumoulin LLP* again reiterated the importance of human rights legislation and the need to take **preventative action** to protect vulnerable groups from discrimination.

[17] The Code is quasi-constitutional legislation that attracts a generous interpretation to permit the achievement of its broad public purposes: Winnipeg School Division No. 1 v. Craton, [1985] 2 S.C.R. 150; Ontario Human Rights Commission v. Simpsons-Sears Ltd., [1985] 2 S.C.R. 536, at p. 547, per McIntyre J.; Canadian National Railway Co. v. Canada (Canadian Human Rights Commission), [1987] 1 S.C.R. 1114, at pp. 1133-36; Council of Canadians with Disabilities v. VIA Rail Canada Inc., [2007] 1 S.C.R. 650.

*[18] Those purposes include the **prevention of arbitrary disadvantage or exclusion based on enumerated grounds, so that individuals deemed to be vulnerable by virtue of a group characteristic can be protected from discrimination. (emphasis added)***

226. Chief Justice Dickson in *CN v. Canada (Canadian Human Rights Commission)*, (*Action des Travaille des Femme*) [1987] 1 SCR 1114 stated:

To combat systemic discrimination, it is essential to create a climate in which both negative practices and negative attitudes can be challenged and discouraged

227. Obligation holders under human rights law have a pro-active obligation to act to prevent and eradicate discrimination without waiting for complaints. They should ensure that work policies, standards and rules are designed for equality from the outset. *British Columbia (Public Service Employee Relations Commission) v. B. C. Government and Service Employees Union (BCGEU)* [1999] 3 S.C.R.3.

228. The Applicant also relies on the recent Canadian Human Rights Tribunal decision, *First Nations Child and Family Caring Society of Canada et al. v. Attorney General of Canada (for the Minister of Indian and Northern Affairs Canada)*.⁸³ The Tribunal found that the federal government's method of funding child welfare services program and other related provincial/territorial agreements across Canada significantly controlled the provision of First Nations children and

⁸² See *Australian Municipal, Administrative, Clerical and Services Union and others Australian Business Industrial*, February 1, 2012 (AM2011/50) [2012] FWAFB 1000 and *Australian Municipal, Administrative, Clerical and Services Union and others*, [2011] FWAFB 2700 May 16, 2011.

⁸³ 2016 CHRT 2 (CanLII)

family services on-reserve and in the Yukon to the detriment of First Nations children and families. The Tribunal concluded that First Nations were adversely impacted and, in some cases, denied adequate child welfare services and concluded that the federal government had knowledge of these shortcomings for many years without correcting it.

229. The *Caring Society* Tribunal found that the federal government had failed to meet its obligation to ensure that its funding of child welfare services does not perpetuate the historical disadvantages endured by Indigenous peoples. It concluded the lack of adequate funding and culturally appropriate child welfare services perpetuates historic disadvantages. The Tribunal ordered the federal government to immediately cease its discriminatory practices and reform its child welfare policies and compensate the First Nations families affected by the discriminatory practices since 2006.

230. The Tribunal has already cited at para. 29 of its Interim Decision to the OHRC Policy and Guidelines on Racism and Discrimination www.ohrc.on.ca These Guidelines refer to the proactive obligations of obligation holders to identify and eradicate systemic discrimination. In the context of racial discrimination, which is equally applicable to gender discrimination, its *Policy and Guidelines on Racism and Racial Discrimination*,⁸⁴ states:

Racial discrimination can result from individual behaviour as well as because of the unintended and often unconscious consequences of a discriminatory system. This is known as systemic discrimination.

Systemic discrimination can be described as patterns of behaviour, policies or practices that are part of the structures of an organization, and which create or perpetuate disadvantage for racialized persons.

*The Commission is very concerned about systemic discrimination. Assessing and tackling systemic discrimination can be complex. **Nevertheless, the Commission expects organizations to be aware that their “normal way of doing things” may be having a negative impact on racialized persons.** (emphasis added)*

231. The Tribunal in its decision, *Grange v. Toronto (City)*, 2014 HRT0 633, also relied on the Commission's above-noted definition of systemic discrimination.'

232. The Commission has set out three considerations that will help the Commission and organizations identify and address systemic discrimination: Numerical data; policies, practices and decision-making processes; and organizational culture. It states:

Organizations must ensure that they are not unconsciously engaging in systemic discrimination. This takes vigilance and a willingness to monitor and review

84 www.ohrc.on.ca

numerical data, policies, practices and decision-making processes and organizational culture. It is not acceptable from a human rights perspective for an organization to choose to remain unaware of systemic discrimination or to fail to act when a problem comes to its attention. (emphasis added)

233. The Commission also highlights in its Guidelines, that it is the responsibility of the obligation holders under the Code to have the necessary institutional mechanisms, including record keeping, in place to ensure they are not engaging in discrimination. For example, the Commission in its *Policy on preventing discrimination because of gender identity and Gender Expression*, states that:

*Organizations and institutions have a positive obligation to make sure they are not engaging in systemic discrimination. They should prevent barriers by designing policies and practices inclusively up front. They should also review their systems and organizational culture regularly and remove barriers where they exist.*⁸⁵

234. Jurisprudence and research has also recognized that systemic discrimination by its nature is not generally plain and obvious to those who suffer from it. Rather it is often hidden and embedded in often seemingly neutral institutional policies, practices and prejudices. In order to combat systemic discrimination, it is essential to look to past patterns of discrimination and to destroy those patterns in order to prevent the same type of discrimination in the future.⁸⁶ The *Alsaigh* HRTO Tribunal decision recognized the need "to be sensitive to the patterned nuances of systemic discrimination."

235. The MOHLTC in its December 4, 2014 Response to AOM Request for Missing Information from MOHLTC Form 2, acknowledged the key role that the *Pay Equity Act*, the *Human Rights Code* and its Guidelines played as its "Internal Human Rights Policies. In response to the following section:

Section 13 – Internal Human Rights Policies a) Do you have a policy related to the type of discrimination alleged in the Application? b) Do you have a complaint process to deal with discrimination and harassment? If there is a policy and complaints process, they are required to be attached to the Response. c) Did the applicant make an internal complaint under the complaints process and if so attach a copy. d) What as the result of the internal complaint and attach a copy of the decision.

Response: The respondent's relevant policies are the Pay Equity Act, RSO 1990, c. P.7 and the Human Rights Code, ROS 1990, c. H.19. The applicant made an application under the Human Rights Code which is currently proceeding.

85 www.ohrc.on.ca.

86 *Action Travail des Femmes v. Canadian National Railway* (1987), 40 D.L.R. (4th) 193 (S.C.C.),

Section 30 of the Human Rights Code authorizes the Ontario Human Rights Commission ["OHRC"] to prepare, approve and publish human rights policies to provide guidance on interpreting provisions of the Code. According to the OHRC's website, the OHRC's policies and guidelines "set standards for how individuals, employers, service providers and policy-makers should act to ensure compliance with the Code. They represent the OHRC's interpretation of the Code at the time of publication. Also, they advance a progressive understanding of the rights set out in the Code." The OHRC has not published any policies or guidelines in relation to pay equity.

236. The Tribunal at para. 29 of its Interim Decision explicitly referred to the OHRC Policy and Guidelines on Racism and Discrimination in its analysis.

c. Comparison with *Pay Equity Act* Obligations

237. To provide context for considering the interpretation of the Code's provisions in this application, it is useful to consider the obligation to provide employment free of systemic gender discrimination in compensation under the *Pay Equity Act*, and in particular, the obligations of the MOHTLC under that *Act* for its own employees and the obligations of the Community Health Centres it funds under that *Act*.
238. The MOHLTC recognizes the relevance of considering analogies to the approach in the *Pay Equity Act* in its Appendix para. 32 where it cites to the *PEA* definition of a male job class for the definition of a male job for *Code* comparison purposes.
239. The Applicant agrees that the Tribunal, *where appropriate*, should consider the applicability of provisions of the *Pay Equity Act*, pay equity practices established to comply with that *Act*, and Pay Equity Hearings Tribunal jurisprudence.
240. Under the *Pay Equity Act*, employers are pro-actively responsible for ensuring that they establish and maintain compensation practices which provide for pay equity. Those obligations started as of January 1, 1988, the effective date of the *Pay Equity Act*. For the Ontario Government, the effect of this legislation meant that it was required to post a pay equity plan as of January 1, 1990 and make any necessary pay equity adjustments to establish pay equity. The obligation to maintain pay equity requires that all compensation practices since January 1, 1998 must continue to provide for pay equity.
241. The MOHLTC has pro-active obligations to redress systemic gender discrimination in compensation and these obligations require that it monitor compensation and retain sufficient records to do so. See *Pay Equity Commission 2012 Guide to the Pay Equity Act*.
242. Under the *Pay Equity Act*, the MOHLTC and other employers are not able to argue that:
- (a) they don't have to do anything until someone complains;

- (b) there is a time limit for complaints of non-compliance;
 - (c) that they are prejudiced in finding documents or witnesses and or that there is any inability to pay accumulated pay equity adjustments; or
 - (d) that they do not have enough money to pay.
243. See decision of the Pay Equity Hearings Tribunal dated October 13, 2000 in *SEIU v. Kensington Village* which states that inability to pay adjustments is not a defence. As well, the Pay Equity Commission 2012 Guide to the Pay Equity states at p. 94, in response to the question "What is the timeframe for making a complaint?" that "There are no time limits. A complaint can be made for any period during which the *Act* has been in effect."⁸⁷ The *Act* has been in effect since January 1, 1988.

d. Independent Contractors for other purposes can be in "Employment Relationship" under the *Code*

244. It is clearly established by the Human Rights Tribunal of Ontario that the term "with respect to employment" encompasses a broad range of relationships relating to employment. Protection is not limited to "employment" relationships in the traditional sense, so long as there is some nexus or link in the chain of discrimination between the respondent and the complainant.⁸⁸ The *Code's* protections extend to preventing unequal treatment on basis of sex to independent contractors and subcontractors. This is particularly so where the person is dependent on the respondent and must work within MOHLTC fiscal constraints in order to provide midwifery services. An entity responsible for a person being treated unequally will therefore be held liable under the *Code* even if the entity is not the person's direct employer.⁸⁹
245. Justice Abella in the May 22, 2014 *McCormick* SCC decision, addressed the context of "employment" as a specific protected context and its application to independent contractors.

[19] The Code achieves those purposes by prohibiting discrimination in specific contexts. One of those contexts is "employment".

87 See *Pay Equity Commission 2012 Guide to the Pay Equity Act* p. 94.

88 *Toronto (Metropolitan) Commissioners of Police v. Ontario Human Rights Commission*, [1979] O.J. No. 4459 For example, *Davey v. Ontario (Health and Long-Term Care)*; 2013; HRTO 419; *Payne v. Otsuka Pharmaceuticals Co Ltd.* (2001), 41 C.H.R.R. D/52; *Garofalo v. Cavalier Hair Stylists Shop Inc.*, 2013 HRTO 170; and *Dopelhamer v. Workplace Safety and Insurance Board*, 2010 HRTO 765.

89 *Davey v. Ontario (Health and Long-Term Care)*, 2013 HRTO 419, *Garofalo v. Cavalier Hair Stylists Shop Inc.*, 2013 HRTO 170, and *Srouji v. Direct IME*, 2012 HRTO 449, *Dopelhamer v. Workplace Safety and Insurance Board*, 2010 HRTO 765, *Halliday v. Van Toen Innovations Incorporated*, 2013 HRTO 583 and *Shinozaki v. Hotlomi Spa*, 2013 HRTO 1027.

[22] The jurisprudence confirms that there should be an expansive approach to the definition of “employment” under the Code. Independent contractors, for example, have been found to be employees for purposes of human rights legislation, even though they would not be considered employees in other legal contexts.⁹⁰

e. Section 3 - Right to Contract on Equal Terms Without Discrimination Based on Sex

246. Section 3 of the Code provides that:

Every person having legal capacity has a right to contract on equal terms without discrimination because of ... sex ...

247. The unequal treatment of an independent contractor is considered to be a violation of the right to contract on equal terms. Contractual terms which result in discrimination will violate section 3 of the Code. *Davey v. Ontario (Health and Long-Term Care)*, 2013 HRTO 419

f. Section 11(1) Constructive or Indirect Discrimination

248. Constructive or indirect discrimination is described in s. 11(1) of the Code which states:

11. (1) A right of a person under Part I is infringed where a requirement, qualification or factor exists that is not discrimination on a prohibited ground but that results in the exclusion, restriction or preference of a group of persons who are identified by a prohibited ground of discrimination and of whom the person is a member, except where,

(a) the requirement, qualification or factor is reasonable and bona fide in the circumstances; or

(b) it is declared in this Act, other than in section 17, that to discriminate because of such ground is not an infringement of a right. R.S.O. 1990, c. H.19, s. 11 (1).

249. Actions which are not discrimination on their face but which adversely impact on women will constitute an infringement of Part 1 of the Code.⁹¹ Section 9 – Infringing Right Directly or Indirectly

90 *Canadian Pacific Ltd. v. Canada (Human Rights Commission)*, [1991] 1 F.C. 571 (C.A.); *Pannu v. Prestige Cab Ltd.* (1986), 73 A.R. 166 (C.A.); *Yu v. Shell Canada Ltd.* (2004), 49 C.H.R.R. D/56 (B.C.H.R.T.). See also *Canada (Attorney General) v. Rosin*, [1991] 1 F.C. 391 (C.A.); *Mans v. British Columbia Council of Licensed Practical Nurses* (1990), 14 C.H.R.R. D/221 (B.C.C.H.R.)

91 *Re: Ontario Human Rights Commission and Simpson Sears Ltd.* (1985) 2 S.C.R. 536; *British Columbia (Public Service Employee Relations Commission) v. B. C. Government and Service*

250. Section 9 of the *Code* provides that:

No person shall infringe or do, directly or indirectly, anything that infringes a right under this Part.

251. A party will be found to infringe any provision of the *Code* whether their action is taken directly or indirectly. *Forrester v. Peel (Regional Municipality) Police Services Board* 2006 HRTO 13 and *D. M. v. Ontario (Ministry of Health and Long Term Care* 2013 HRTO 1034. .

g. Section 12 - Prohibition against Associational Discrimination.

252. Section 12 of the *Code* prohibits discrimination because of association and provides that:

A right under Part I is infringed where the discrimination is because of relationship, association or dealings with a person or persons identified by a prohibited ground of discrimination. R.S.O. 1990, c. H.19, s. 12.

253. Discrimination because of association with women who are persons identified by a prohibited ground of discrimination constitutes discrimination within the meaning of s.12.
254. Where an entity is so imbued with the identity or character of its membership, or so clearly representative of a group that is identified by a prohibited ground under the *Code*, that they cannot be separated from them, the entity itself takes on the protected characteristic.⁹²

h. Duty to Take Reasonable Steps to Address Human Rights Concern

255. There is a duty to take reasonable steps to address allegations of work discrimination and a failure to do so may itself result in liability under the *Code*:⁹³This includes acting promptly, taking a complaint seriously, having a complaint mechanism in place and communicating actions to the person or entity which complained. *Abdallah v. Thames Valley District School Board*, 2008 HRTO 230 (CanLII), 2008 HRTO 230 (CanLII), at para. 87

i. Injury to Dignity, Feelings and Self-Respect

256. Compensation is a central component of a person's employment conditions. As highlighted by the Supreme Court of Canada in *NAPE*,⁹⁴ the conditions in which

Employees Union (BCGEU [1999] 3 S.C.R.3 and *Andrews v. Law Society of British Columbia*, (1989) 1 S.C.R 143.

92 *Brillinger v. Brockie* [1999] O.H.R.B.I.D. No.12.

93 *Moffatt v. Kinark Child and Family Services*, [1998] O.H.R.B.I.D. No. 19, *Laskowska v. Marineland of Canada Inc.*, 2005 HRTO 30 (CanLII), 2005 HRTO 30 (CanLII).

94 *Newfoundland (Treasury Board) v. N.A.P.E.*, 2004 SCC 66 at para.40;

a person works are highly significant in shaping the psychological, emotional and physical elements of a person's dignity and self-respect. This is because a person's employment is an essential component of their sense of identity, self-worth and emotional well-being. As the court stated:

*For many people what they do for a living, and the respect (or lack of it) with which their work is regarded by the community, is a large part of who they are. Low pay often denotes low status jobs, exacting a price in dignity as well as dollars.*⁹⁵

257. The Tribunal has applied two criteria in making the global evaluation of the appropriate damages for injury to dignity, feelings and self-respect: the objective seriousness of the conduct and the effect on the person who experiences the discrimination. The more prolonged the discrimination, the greater injury.⁹⁶
258. Monetary compensation as a remedy for injury to dignity, feelings and self-respect recognizes that the injury to a person who experiences discrimination can be psychological in nature, and engages more than quantifiable losses such as lost wages. Damages under the *Code* must not be so low as to trivialize the social importance of the Code by effectively creating a license fee to discriminate.
259. Failure to pay equitable compensation and recognize the professional expertise of women will justify a significant order for compensation for injury to dignity, feelings and self-respect *Walden v. Canada (Social Development)* 2009 CHRT 15 (Canlii)

Part 12 The Code Test for Discrimination

260. The Ontario Court of Appeal has provided an enumerated list of what an applicant must demonstrate in order to establish *prima facie* discrimination:⁹⁷
 - (a) That he or she is a member of a group protected by the *Code*;
 - (b) That he or she was subjected to adverse treatment; and
 - (c) That his or her gender, race, colour or ancestry was a factor in the alleged adverse treatment.⁹⁸
261. The applicant bears the onus of demonstrating the three elements of *prima facie* discrimination. The evidentiary burden then shifts to the respondent to refute the

95 Ibid at para.48

96 *Arunachalam v. Best Buy Canada* 2010 HRTO 1880, at paras. 52-54.

97 *Toronto (City) Police Services v. Phipps*, 2012 ONCA 155 at para 14.

98 See *Toronto (City) Police Services v. Phipps*, 2012 ONCA 155(CanLII), at para 14).

allegations made or to justify the conduct. If the conduct cannot be justified, discrimination will be found to have occurred.⁹⁹

262. The Court of Appeal clarified this test in *Peel Law Assn v Pieters*, 2013 ONCA 396 (CanLII):

"[The] prima facie case test defines what is necessary to establish substantive discrimination. It is no different than in every other evidentiary context. Since a prima facie case involves evidence that, if believed, would establish the claim, a respondent faced with a prima facie case at the end of the claimant's case must call evidence to avoid an adverse finding" (para 65).

The standard of proof in satisfying the *prima facie* test is as follows:

"In discrimination cases...the law, while maintaining the burden of proof on the applicant, provides respondents with good reason to call evidence. Relatively 'little affirmative evidence' is required before the inference of discrimination is permitted. And the standard of proof requires only that the inference be more probable than not. Once there is evidence to support a prima facie case, the respondent faces the tactical choice: explain or risk losing" (*Pieters*, *ibid*, at para 73).

263. In the recent case of *Quebec v. Bombardier Inc.*,¹⁰⁰ the Supreme Court of Canada stated as follows:

In our opinion, even though the plaintiff and the defendant have separate burdens of proof in an application under the Charter, and even though the proof required of the plaintiff is of a simple "connection" or "factor" rather than of a "causal connection", he or she must nonetheless prove the three elements of discrimination on a balance of probabilities. This means that the "connection" or "factor" must be proven on a balance of probabilities. (para 56)

264. The Supreme Court also confirmed that an applicant is not required to prove that the respondent intended to discriminate against him or her, and that some forms of discriminatory conduct are unconscious and/or systemic.¹⁰¹ In addition, an applicant need not establish that the factor was the sole or primary "cause" of that conduct.¹⁰²
265. The *Bombardier* Court noted that a flexible, contextual approach is still required in a human rights context'

99 *Moore v British Columbia (Education)*, 2012 SCC 61 at para 33.

100 *Quebec v. Bombardier Inc.*, 2015 SCC 39 at para 65 [*Bombardier*].

101 *Ibid.* at paras 32, 40-41.

102 *Ibid.* at paras 40-54, 56.

*“Thus, although the nature of the evidence that is presented may vary from case to case, the “legal test” does not change. What can vary are the circumstances that might make it possible to meet the requirements of the various elements of the analysis, and the courts must adopt an approach that takes the context into account.”*¹⁰³

266. In *Moore v British Columbia (Education)*, 2012 SCC 61 (CanLII), Abella J. of the Supreme Court of Canada set out what is considered the traditional configuration of the test for finding discrimination in context of individual discrimination:

“[To] demonstrate prima facie discrimination, complainants are required to show that they have a characteristic protected from discrimination under the Code; that they experienced an adverse impact with respect to the service; and that the protected characteristic was a factor in the adverse impact. Once a prima facie case has been established, the burden shifts to the respondent to justify the conduct or practice, within the framework of the exemptions available under human rights statutes. If it cannot be justified, discrimination will be found to occur” (para 33).

267. In its simplest configuration, a *prima facie* case “is one which covers the allegations made and which, if they are believed, is complete and sufficient to justify a verdict in the complainant's favour in the absence of an answer from the respondent-employer”¹⁰⁴.

268. The burden shifts from the applicant to the respondent once the applicant has established his, her, or its *prima facie* case. To succeed in meeting this threshold, the applicant must put forth evidence that is both credible and sufficiently linked, on a balance of probabilities, to a protected ground under the *Human Rights Code*.

269. In *British Columbia v Crockford*,¹⁰⁵ the British Columbia Court of Appeal explained the distinct type of evidence required in the context of an allegation of systemic discrimination:

*A complaint of systemic discrimination is distinct from an individual claim of discrimination. Establishing systemic discrimination depends on showing that practices, attitudes, policies or procedures impact disproportionately on certain statutorily protected groups [...]. A claim that there has been discrimination against an individual requires that an action alleged to be discriminatory be proven to have occurred and to have constituted discrimination contrary to the Code. **The types of evidence required for each kind of claim are not***

103 Ibid, para 69

104 (*Ontario (Human Rights Commission) v Simpsons-Sears Ltd.*, 1985 CanLII 18 (SCC), at para 28 [*Simpson-Sears Ltd.*])

105 *British Columbia v Crockford*, 2006 BCCA 260 at para 49 (emphasis added).

necessarily the same. Whereas a systemic claim will require proof of patterns, showing trends of discrimination against a group, an individual claim will require proof of an instance or instances of discriminatory conduct. (emphasis added)

270. In *Persaud v Toronto District School Board*, 2009 HRTO 1721 (CanLII), the Tribunal enumerated five factors that should guide the respondent in a discrimination case:

"1) Once a *prima facie* case of discrimination has been established, the burden shifts to the respondent to provide a rational explanation which is not discriminatory.

2) It is not sufficient to rebut an inference of discrimination that the respondent is able to suggest just any rational alternative explanation. The respondent must offer an explanation which is credible on all the evidence.

3) A complainant is not required to establish that the respondent's actions lead to no other conclusion but that discrimination was the basis for the decision at issue in a given case.

4) There is no requirement that the respondents' conduct, to be found discriminatory, must be consistent with the allegation of discrimination and inconsistent with any other rational explanation.

5) The ultimate issue is whether an inference of discrimination is more probable from the evidence than the actual explanations offered by the respondent" (para 182).

271. It is therefore a discretionary exercise wherein the Tribunal must balance the evidence adduced by both the applicant and the respondent.

Part 13 What Does This Jurisprudence Mean for How the Evidence Should be Viewed?

272. It is respectfully submitted that the Tribunal, based on statements from its Interim Decision, court decisions cited in that ruling and above, should approach the hearing of whether there is systemic discrimination in compensation and in the MOHLTC compensation/fee setting practices by looking at many different factors including:

(a) Assess whether the midwives are a "vulnerable" group who experienced historical disadvantage and prejudice? This element is already clearly documented by the 1987 TFIMO Report which the Government relies upon as the foundation document for the OMP. It is also referred to in Cabinet and other government documents

(b) Examine the "roots deep in history and in societal attitudes" Para. 32

- (c) View "as comprehensively as possible" the pay setter's (here the MOHLTC's) "pay practices and policies as they affect the wages of men and women". Para. 31
 - (d) Examine the evidence comprehensively and in aggregate to see the patterns of "action and inaction". Para. 32
 - (e) Assess whether there is a Ministry "application over time of wage policies and practices that have tended either to ignore or undervalue work typically performed by women" and the "impact of policies, practices and systems over time, often a long period of time."
 - (f) Examine the "results" of Ministry's compensation setting systems for midwives and CHC physicians and other professions. Para. 30
 - (g) Consider the impact of "the simple operation of established procedures" for budgeting, funding, and compensation setting "none of which is necessarily designed to promote discrimination" Para. 30
 - (h) Examine the "interrelationships between actions (or inaction), attitudes and established organizational structures." Para. 33
 - (i) Examine whether the respondent has sought to "prevent all discriminatory practices," based on sex which contribute to systemic gender discrimination in compensation. See Chief Justice Dickson quote cited at para. 35 Interim Decision.
273. The AOM submits that its evidence – expert and non-expert is directed at examining the above issues and that the evidence strongly points to a systemic set of actions and inactions which contributed to sex based pay inequity for midwives since 1997.

Part 14 Prima Facie Case of Discrimination Established based on Agreed Facts and Documents

274. The Applicant submits that the it has established a prima facie case of discrimination under the Code even before the hearing of evidence starts based on the agreed facts and documents to date. As a result, we take the position that onus has shifted to the MOHLTC to show that its actions are free of sex-based discrimination.
275. In order to satisfy the *prima facie* test – and have the onus of (dis)proving the allegations shift to the respondent, the applicant must credibly link the treatment of the midwives to a protected ground under the *Code*. This has already been done in great measure.
276. As detailed above, the Ontario Government both through the *Pay Equity Act*, its policy statements and official documents and Pay Equity Hearings Tribunal

decisions have established that Ontario women in general, particularly those in sex segregated work traditionally associated with "women's work" experience systemic undervaluation of their work and pay.

277. The specific factors here in this case for midwives which contribute to the connection of sex and gender with midwifery compensation both prior to regulation and thereafter to the present date include the following:
- (i) Midwives are a protected group. Midwives are the most highly female and sex segregated health care profession at 99.9% female.
 - (ii) Midwife means "with women". Midwives provide health care services for women. Midwives are closely associated with the women for whom they provide midwifery services. Midwives provide such services in relation to a biologically female experience of pregnancy and birth;
 - (iii) Midwives are closely associated with women's health care. The TFIMO and other Government reports have documented the concerns of women with respect to their health care and requirement for gender-sensitive proactive approach.
 - (iv) The Government's own documents, including the Task Force on Implementation of Midwifery, the regulation process documents referred to in the AOM Overview Summary and Cabinet and government documents since recognize midwifery as a female dominated profession doing women's work for women with respect to women's health care.
 - (v) Work and occupations associated closely with women is vulnerable to systemic undervaluation and underpayment – a gender penalty or discount. This is well documented in the Government's 1986 Green Pay on Pay Equity which lead to the *Pay Equity Act*; the preamble to the *Pay Equity Act*, recent Government statements, academic research, the Durber, Armstrong and Bourgeault expert reports, Pay Equity Commission documents, recent Government ministerial statements and mandates, the Gender Wage Gap Review consultation documents and human rights jurisprudence.
 - (vi) Gender is also recognized to advantage work performed by or associated with men which is consistently paid more on average than work performed by women.
 - (vii) Midwives have been subjected to historical stereotyping and prejudices with respect to the value and contributions of their work, including their exclusion from the health care system for almost a century. The Government recognized this gendered context and disadvantage when it put the MOHLTC Women's Health Bureau

initially in the lead in the developing the new funded system and developed a process design to equitably integrate the female dominated profession of midwives into the funded system.

- (viii) Government recognized on regulation the gendered context of health care and the power of the male dominated medical profession to resist midwifery integration; Government documents recognize the ongoing barriers midwives face particularly with respect to barriers they face in hospitals to practising to their full scope of practice.
- (ix) Physicians continue to restrict midwives in their practice in order to secure more intrapartum and other maternity care work for physicians.
- (x) Midwives filed statements and the Government's own documents show that they continue to be subjected to prejudice, barriers and disadvantages.
- (xi) Midwives have been subjected to adverse treatment in their compensation treatment since 1994 with their compensation frozen over many years, the failure to provide them with the same compensation setting mechanisms as provided for male dominated physician work and the refusal to monitor and apply a human rights sex/gender lens to ensure that the original rough pay equity analysis and positioning of their work in the male dominated health care hierarchy was continued.
- (xii) The historical incumbency of CHC physician prior to 1993 draws from heavily dominated physician pool The CHC physician male comparator was clearly male predominant at the time of the original 1993 Work Group analysis and the AOM expert reports clearly establish the male dominance of the compensation setting mechanisms used to set CHC physician work after that date, even though more women entered the position.
- (xiii) In any event, alternatively, it is also established as a precedent through Ontario's *Pay Equity Act* and relying on the expert evidence of Dr. Pat Armstrong that it may be necessary to use a female predominant job with identified equitable pay as a proxy measuring stick for male work in predominantly female workplaces who which do not have sufficient numbers of male comparators to use the job to job comparison method or the proportional value comparison methods. This method which looks at comparators outside the establishment known as the proxy comparison method is the legislative choice upheld by Mr. Justice O'Leary as a

necessary tool to identify discrimination in the 1997 Court decision *SEIU Local 204 v. Attorney Gen (Ont)*.

- (xiv) The documents produced by the MOHLTC, some produced in the last few weeks show a history over the last nearly 20 years of constantly freezing midwifery pay or giving small adjustments while at the same time going to great lengths to increase the compensation of the CHC physician and other work. These actions were carried out by the same Branch which administered and set the compensation for both positions.
- (xv) Subsequent to the basically gender-sensitive process which was used to establish midwifery compensation in the gendered health care hierarchy, thereafter, the MOHLTC continued to make the decisions about midwifery compensation but did so without any reference to equitable considerations or to any systematic analysis of the SERW and pay of the work relative to the original male comparator.
- (xvi) With the OMP a constantly expanding program because of the shortage of midwives and the constant influx of new registrants to meet that consumer demand, the Government relied on continuing the underpayment of midwifery work in order to finance expansion of the service. CHC physicians were not expected to similarly finance the expansion of the CHC Centres.

278. Cabinet documents and government evaluations during the period when midwives compensation was frozen show:

- (a) Midwives were and in high demand and there was and is an extreme shortage of midwives which will continue for years to come;
- (b) Midwifery attrition both within the MEP and afterward in practice has been a significant concern:
- (c) The outcomes produced by midwifery care are highly effective from a clinical and health system perspective;
- (d) The use of midwives was cost effective;
- (e) The OMP was highly consistent with the Government's primary health care reform initiatives as a managed health care service where services could be targeted by the Government to specific geographic areas and needs around the province: and.
- (f) The consumers of midwifery services valued the service and wanted more midwives;

279. The compensation of midwives over this period was not decided through any evaluation process or pay equity/human rights analysis to ensure it was gender equitable.
280. When the MOHLTC started getting very specific demands from the AOM in November 2000 forward that the MOHLTC should provide equitable compensation back to 1994, the MOHLTC failed to address that request, even though it funded a Hay Report for the CHCs which was subsequently used to increase the compensation of CHC physicians. When the AOM went out and also contracted Hay to do a compensation report, that report done in 2003 and updated in 2004 was not acted on. It was not until the midwives mounted a public campaign backed by midwifery consumers leading to a demonstration in December 2004, that the OMP agreed to provide more funding which could in part be used to increase the compensation of midwives.
281. The MOHLTC continued to advise the midwives that it did not have sufficient funding in the budget to address the claim of inequitable compensation. Unlike the situation for pay equity adjustments required under the Pay Equity Act, the MOHLTC did not consider that the adjustments necessary to ensure a gender equitable compensation structure should be funded separately as a human rights remedy. Instead, the Government viewed the AOM's claims for equitable compensation as a regular wage increase which it declined to provide even though at the same time it was providing adjustments to the CHC physicians and other male work in the Ontario. For a review of some of the adjustments paid to CHC physicians and midwives, see the AOM Overview Summary of Evidence, Appendix 2 and see Part above re: CHC physician compensation.
282. If the midwives were employed in a hospital or in a Community Health Centre, the Pay Equity Act would be applicable to them and they would clearly be a female job class which would need to be proactively assessed on the basis of the skill, effort, responsibility and working conditions relative to other male dominated work or the proxy for that work. Midwives were not "employed" in order to meet client needs and yet are denied pay equity protection by the Ministry a result of that status.

Part 15 Government and Legislated Recognition of Importance of Closing Ontario's Gender Pay Gap and Promoting Gender Equality in Pay and Work

a. Eliminating Systemic Gender Discrimination in Compensation is Public Policy and Law in Ontario

283. It is public policy in Ontario that action must be taken to close the gender pay gap in Ontario which means that women on average earn between 12-31.5% less than men in Ontario. The Report of the provincially appointed Gender Wage Gap Review Committee is due this month. While the MOHLTC has been marshalling

major resources to fight this application, at the same time it is publicly stating that it is committed to closing the gender pay gap.¹⁰⁶

b. Government Mandate Letters to Close Ontario's Gender Pay Gap

284. Premier Kathleen Wynne in September 2014 issued Mandate Letters to two Ministers which require the development of a strategy and plan to close Ontario's gender pay gap and to apply a gender lens to government decision-making.

The Premier has mandated the Minister of Labour to: Develop a Wage Gap Strategy

"Women make up an integral part of our economy and society, but on average still do not earn as much as men. You will work with the Minister Responsible for Women's Issues and other ministers to develop a wage gap strategy that will close the gap between men and women in the context of the 21st century economy."¹⁰⁷

The Premier has mandated the Minister Responsible for Women's Issues to: Promote Gender Equality in Ontario

"play a key role in ensuring that every person who identifies as a woman or a girl is able to participate as a full member of our society, exercise their rights – and enjoy their fundamental freedoms in the social, economic and civil life of our province. Your priority will be to promote gender equality in Ontario, reflecting the diversity of our communities by taking a comprehensive approach to addressing the social and economic conditions that create inequalities."

The Premier has mandated the Minister Responsible for Women's Issues to: Collaborate with Colleagues Across Government re: Applying Gender Lens to Government Strategies, Policies and Programs

"support the Minister of Labour in the development of a wage gap strategy... and collaborat(e) with colleagues across government to ensure that a gender lens is brought to government strategies, policies and programs."¹⁰⁸

¹⁰⁶ Closing the Gender Wage Gap: A Consultation Paper for Businesses and Organizations, Ministry of Labour, October, 2015, http://www.labour.gov.on.ca/english/about/pdf/gwg_consultation.pdf.

¹⁰⁷ Letter from Premier Kathleen Wynne to Minister of Labour Kevin Flynn dated September 25, 2014, <http://www.ontario.ca/government/2014-mandate-letter-labour>.

¹⁰⁸ Letter from Premier Kathleen Wynne to Minister Responsible for Women's Issues, Tracy MacCharles dated September 25, 2014, <http://www.ontario.ca/government/2014-mandate-letter-womens-directorate>.

c. Gender Wage Gap Consultation by the Ministry of Labour's Gender Wage Gap Steering Committee:

"We need to close the gender wage gap and eliminate inequity for women in the work force. It's the right thing to do, and I look forward to hearing back from the Steering Committee on how we can take next steps to reduce and eliminate the gender wage gap in Ontario." Minister of Labour Kevin Flynn

"While women participate in all parts of the workforce, there are still barriers that prevent women from achieving their economic potential. That negatively affects Ontario's prosperity. Our government recognizes that when we are all treated equitably, we all benefit. That's why we are taking action today, for a more equal and economically sound Ontario." Minister Responsible for Women's Issue, Tracy MacCharles

"Gender wage gaps show that workplace inequalities continue to exist. Nearly half of the Ontario workforce is female, yet women earn less than men throughout their working lives. Despite increased participation in the workforce and higher levels of education and increased skills, women still face significant barriers and disadvantages in employment compared to men".¹⁰⁹ Gender Wage Gap Steering Committee

d. Minister of Labour's Statement on Equal Pay Day April 20, 2015

Speaker, today we recognize the critical role that women play in our economy, while reflecting on the sombre reality that women continue to earn less on average than men.

Equal Pay Day is a reminder that we must dedicate ourselves to ending this discrimination and ensuring that the great contributions women make to our economy and the Province of Ontario are fully valued and recognized. (emphasis added)

Our Government is committed to women's equality in Ontario. We have increased women's economic opportunities and removed barriers preventing full participation by women in the labour force. The Gender Wage Gap Strategy that the Steering Committee will draft will build on the progress we've made and will significantly improve the economic outcomes for Ontario women and of the province as a whole.

109 Closing the Gender Wage Gap: A Consultation Paper for Businesses and Organizations, Ministry of Labour, October, 2015, http://www.labour.gov.on.ca/english/about/pdf/gwg_consultation.pdf. See also, Closing the Gender Pay Gap: A Background Paper, Ministry of Labour, October, 2015 which addresses the key factors associated with the gender wage gap including discrimination, occupational segregation, caregiving activities and workplace culture and education. at p. 33 onwards.

By acknowledging this day, Speaker, Ontario joins others around the world in recognizing that while we've made significant progress, this inequality still exists and we still have more work to do.

Recognizing the value of the work that women do contributes to a more equal, just and prosperous society.

Our goal is an Ontario where men and women have equal opportunity to achieve their full potential within a modern workplace, thus contributing to Ontario's economic growth.

Closing the gender wage gap is a necessary part of this goal.

e. Statement from Chief Commissioner of the Ontario Human Rights Commission on Equal Pay Day, April 19, 2016

285. On Equal Pay Day, April 19, 2016, the Chief Commissioner issued a public statement on the gender wage gap and human rights. – "One Hundred and 10 Day Short of Equality for Women"¹¹⁰

"Globally, and here in Ontario, society continues to devalue women's contributions to the workforce. In March, UN Women issued a call to action to close the gender pay gap, and is working to develop an international coalition that will bring urgent progress on equal pay. The UN Secretary-General's newly-formed High Level Panel on Women's Economic Empowerment includes the gender wage gap as one of its key issues.

Ontario's Pay Equity Act was enacted in 1987 – nearly 30 years ago – to redress systemic gender-based wage discrimination in workplaces. More recently, the Government of Ontario committed to creating a gender wage gap strategy, which will look at systemic approaches to solving this complex problem. But the gender wage gap persists and the problem will not be solved through government action alone.

Addressing this nuanced, multifaceted issue and intersectional discrimination requires ongoing effort and a comprehensive approach, and the involvement of government, employers, industry, services and yes, the human rights system."

As a first step, society needs to acknowledge that the gender wage gap is the result of continued systemic discrimination against women. Ontario's Human Rights Code aims to create equitable societies where everyone has a right to equal treatment without discrimination or harassment based on 17 personal characteristics, or grounds – including sex. The gender wage gap is inconsistent

110 <http://www.ohrc.on.ca/so/node/17611>.

with the goals and values that are the foundation of the Code and in that sense, pay equity is a fundamental human right.

The Code provides mechanisms to address individual gender wage discrimination concerns. Women can make complaints through the human rights system or the Pay Equity Commission. But in most cases, this redress is available only after the damage is done.

In 2016, women shouldn't have to fight to be paid fairly for their work"

Part 16 Review of AOM Expert Evidence

286. The AOM expert evidence is summarized in Appendix 3. The evidence provides substantial support for the AOM claims and also rebut the claims of MOHLTC experts.

a. Paul Durber

287. Pay Equity expert Paul Durber produced a proportional value pay equity analysis of the work of midwives, CHC physicians and the CHC Nurse Practitioner by measuring skills, effort, responsibilities and working conditions using the "Equitable Job Evaluation Factor Plan" and using a contextual sex-based gender analysis. Mr. Durber describes that this Gender-Neutral Comparison tool reflects the values of the primary health care framework and values of the MOHTLC.

288. Mr. Durber concluded that the job valued most highly is the CHC family physician (100%); next is the midwife (at 91% of the value of the CHC family physician), and third is the nurse practitioner (at 79%).

289. Mr. Durber went on to conclude that since the midwife is receiving just 53% of the compensation of the CHC physician, when her work is valued at 91% of the CHC physician, there is a difference in percentage value points of 38%.

290. Mr. Durber relied on Mr. Mackenzie to calculate the midwifery gender pay gap which is about 48%.(based on current calculations.)

291. Mr. Durber's report details the historical pay gap of the midwife and CHC physician by looking at the following periods of time and assessing the value of midwifery work in relation to the CHC physician.

(a) January 1, 1994 to December 31, 1996: 80%

(b) January 1, 1997 to December 31, 1999: 84%

(c) January 1, 2000 to December 31, 2002: 84%

(d) January 1, 2003 to December 31, 2005: 85%

- (e) January 1, 2006 to December 31, 2008: 89%
- (f) January 1, 2009 to December 31, 2012: 91%¹¹¹

292. Mr. Durber's report notes areas for further analysis and also reviews the assumptions made in his report. Assumptions include relying on the amount of hours worked by midwives in 1993, though a 2007 report demonstrates that midwives work around 10% more hours than originally assessed in the 1993 end year. Mr. Durber notes that his report only assessed direct wages and not indirect wages such as benefits, which would also be subject to a wage gap and need to be remedied. Mr. Durber also notes that he gave the CHC physician full credit for the highest demands in the job description or literature, including births. It is now agreed that CHC Physicians do not (with some exceptions) perform intrapartum care.
293. Mr. Durber's Response Report points to various analytical components of a pay equity analysis that were missing from the MOHLTC's expert reports, the most notable of which is the absence of any gender equality/pay equity analysis to determine whether sex is a factor operating in the compensation of midwives. His response report responds in some detail to the November, 2014 MOHLTC expert report statements justifying the difference in compensation between midwives and CHC physicians.
294. Mr. Durber made various corrections to his 2013 Report, which were the result of a transcription error, the transposition of scores between two factors, and the fact that one score was not updated in the substantiating information in Annex 6 to his report. The effort of these errors was the addition of 6 points to the value of the CHC physician work, which slightly altered the proportional relationship between the jobs by about 0.5%. This had an effect of altering the value of the midwives' work by 1% for every year but 2013, where the points stayed the same. These corrected points are reflected above.

b. Hugh Mackenzie

295. Economist Hugh Mr. Mackenzie's report analyzed the actual monetary pay equity adjustments required as a result of the above-noted Durber analysis.
296. Mr. Mackenzie's response report response to various of the critiques raised by the MOHLTC experts about his report. He also highlights a number of problematic aspects relating to job evaluation in the MOHLTC expert reports.
297. Mr. Mackenzie's analysis includes three different scenarios and provides the cost for each (although without yet calculating the actual full value of the benefits differential and without including the increases in physician compensation

111 Taken from Durber Response Report.

disclosed more fully in recent document productions. The calculations below will now need to be adjusted to reflect this updated information).

298. Based on the information set out in his report, these scenarios are as follows:
- (a) Maintaining the relationship between midwives' compensation and the male comparator Community Health Centre physicians established in the Midwifery Funding Working Group (the Morton Report);
 - (b) Re-evaluating the relationship between midwives and CHC physicians on the basis of the Paul Durber Pay Equity analysis of the relative value of midwives' and CHC physicians' work for the period 1994 to date.
 - (c) Maintaining the real value of midwives' 1994 compensation, as was provided for in the Ministry's September 1993 Ontario Midwifery Funding Framework. That Framework provided for periodic cost of living adjustments to the pay rates established effective 1994.
299. The Mackenzie report concludes as follows:
- (a) *Establishing Pay Equity effective 1997 and maintaining Pay Equity throughout the period 1997 to 2013 through periodic re-evaluations of the relative value of the duties and responsibilities of the male comparator CHC physicians and midwives as outlined in the Paul Durber Pay Equity analysis, 2013 pay for midwives would be \$197,315 -- \$94,800 higher than the current actual midwives' compensation.*
 - (b) *Even without considering the updated Pay Equity analysis, midwives' compensation has fallen far behind the comparative basis established by the Morton Report for 1994. If the relationship implicit in the Morton Report – 63% of the CHC physician maximum – had been maintained, instead of midwives' annual rate of compensation in 2013 of \$101,704, it would have reached \$136,000.*
 - (c) *Had midwives' compensation been adjusted to reflect changes in the cost of living, as was provided for in the 1993 midwives' compensation Framework, midwives' compensation would have reached \$110,600 -- \$8,000 higher than the current level.*
 - (d) *Since 1994, Midwives' compensation has increased by 33%. Over the same period, the male-dominated CHC physicians' maximum compensation (the CHC physician maximum) has increased by 76%. The CHC minimum has increased by more than 119%.*
 - (e) *Midwives' compensation has increased at a much lower rate than that of the (female-dominated) job category of nurse-practitioner. Up to the point where both midwives' and nurse-practitioners' compensation were frozen in 2009, midwives' compensation had increased by 33%; nurse-practitioners' by 59%.*

(f) *It appears from a comparison of midwives' actual and inflation-adjusted 1994 compensation that the adjustments in 2005 and from 2005 to 2009 had the effect not of re-establishing the Morton Report's 1994 relationship to the comparative health care providers, but merely of restoring the real (inflation-adjusted) value of their 1994 compensation level.*

(g) *Midwives' compensation has fallen well behind the key general comparator, average wages and salaries in the health care and social services sector. Whereas midwives' compensation increased by 33% over the 20-year period, average weekly wages and salaries in the health and social services sector have increased by 64%.*

(h) *Over the period 1994 to 2013, the compensation of midwives in Ontario declined in real terms (after adjusting for inflation). Midwives' compensation has increased by 33%; inflation was 44%.¹¹²*

300. In addition, the Mackenzie report also estimates the compensation losses arising from the unequal benefits which midwives were also receiving. The Mackenzie report contains an estimated total summary of the compensation losses set out below. A proper accounting will be necessary based on compensation records in the possession of the Ministry to finalize the compensation losses owing.

Cash Compensation

Nominal amount owed to the date of Application (27 November 2013)
\$317,722,513

Interest calculated in accordance with the Hallowell methodology \$ 2,065,196

Total amount of retroactivity owed with respect to cash compensation
\$319,787,710

Increased allocation for benefits arising from applying 20% formula to all cash compensation

Nominal amount owed \$ 63,572,725

Interest \$ 413,223

Total amount of retroactivity owed with respect to benefits allocation

\$ 63,985,948

¹¹²

Mackenzie Expert Report, supra at pp 2-3. Note: these calculations do not include impact of inequitable benefits. See. Chart 2 of the Mackenzie report for a graphic demonstration of the inequitable compensation faced by midwives as a result of the above-noted Ministry actions.

Total Retroactivity \$383,773,658

c. Dr. Pat Armstrong

301. Dr. Pat Armstrong is Canadian and international expert in the field of work, women's work, compensation, pay equity, job evaluation, social policy (especially gender equality promoting analysis, policies and laws), and in health care and social services.
302. Dr. Armstrong explains the dynamics and nature of systemic gender discrimination in compensation in the context of Ontario's highly gendered and sex segregated health care system. She concludes such discrimination affects all types of women's work, however it is structured.
303. Dr. Armstrong based on her extensive experience and expertise concludes that providing women with pay equity - compensation free of discrimination - requires proactively making visible and valuing women's work. This involves a gender-based analysis and positive action by those setting women's pay, including the mechanism of comparing the jobs done predominately by women with those done predominately by men to allow the calculation of a pay equity gap. She notes that this requires a process of evaluation based on multiple sequential steps: 1) determining gender predominance; 2) making the skills, effort, responsibility and working conditions visible and valuing them appropriately; 3) identifying compensation; 4) then assessing whether there are any reasons for pay differences that are free of gender bias; 5) adjusting compensation; 6) ensuring that compensation free of gender bias is maintained.
304. Dr. Armstrong concludes that midwifery work is work currently and historically done primarily by women, long associated with women's natural attributes, has often been hidden in the household and is embedded in a hierarchical health care system that has been dominated by doctors, most of whom are men.
305. Dr. Armstrong concludes that CHC physicians are appropriate comparators for midwives in identifying whether systemic gender discrimination is operating in their compensation. She reviews the historical exclusion of midwives from Canada's health care systems and how this reflects the power and prejudices of the primarily male physicians who were mainly interested in protecting their financial interests as well as their monopoly over childbirth. She highlights the importance of the equality role for governments in providing mechanisms to ensure that compensation is free of gender discrimination.

d. Dr. Ivy Bourgeault

306. Dr. Bourgeault is a Professor of Health Administration at the Telfer School of Management, a Principal Scientist at the Institute of Population Health at the University of Ottawa and the Canadian Institutes of Health Research Chair in Gender, Work and Health Human Resources.

307. Dr. Bourgeault examines the history of midwifery regulation in Ontario drawing upon her research book, PUSH which documented and analyzed the history and regulation of midwifery. She concluded that when midwifery was being established, there was an explicit attempt to have an evidence-based analysis of the work of midwives reflecting their model of practice and reflecting a pay equity framework of skills, effort, responsibility and working conditions (the Morton Report).
308. She also concludes that the dominance of the medical profession within the Ontario health care division of labour and the maternity care system was achieved in part through the exclusion of midwives from the system historically. She concludes that physicians are still very much a male dominated profession in spite of the recent and rapid expansion of a number of women into their ranks. Female health professions, such as midwifery and nursing, remain distinct and separate from the dominant medical profession.
309. Dr. Bourgeault also concludes that the midwifery and physician/nurse model of care are very different and should not be considered substitutes. The midwifery model is less interventionist, not reliant upon nursing care for labour support and requires a significant amount of time being on call. Consistent with the findings of the TFIMO Report, she concludes that the medical model is a male-derived framework for care which is a product of its historical roots in the industrial revolution and rise of biomedical science. Pregnancy and labor, by extension, were not seen as natural life processes but as critical illnesses which need to be managed and are only considered safe or 'normal' in retrospect.
310. She notes that midwives and CHC physicians have very different work-life balances. While midwives are constantly on-call, CHC physicians for the most part work on salary according to a 9-5 type of work schedule.
311. Dr. Bourgeault observes that the unequal compensation and unequal bargaining process for midwives through the AOM and CHC physicians through the OMA is yet another instance of the invisible, privileged and structural embeddedness of medical dominance within the health care division of labour, expressed in this instance with respect to professional remuneration and public funding.

Part 17 Have the MOHLTC Witness Statements and Expert Reports Challenged the AOM Evidence?

a. Critiques of MOHLTC Evidence by AOM Witnesses

312. The MOHLTC Expert reports have been substantially critiqued by the AOM's experts in their reports and this is highlighted and summarized in Appendix "3" attached to this Statement. Essentially the MOHTLC experts view of the facts and their conclusions also contribute to the systemic gender discrimination in compensation suffered by midwives.

313. The AOM Overview Summary of Witness Evidence also contains evidence which substantially contradicts the facts relied upon by the MOHLTC reports and therefore the conclusions reached. As well, the individual witness summaries filed by the AOM, particularly by Katrina Kilroy, a former AOM President, Kelly Stadelbauer, AOM Executive Director contain detailed critiques of the facts relied upon by the MOHLTC experts.
314. The MOHLTC has adopted all of its expert reports as its position. See December 4, 2014 MOHLTC Response to AOM Request for Particulars.
315. Government experts are speculating as to why the Government paid doctors substantially more than midwife. They did not appear to have access to government documents about what actually happened and their speculations are wrong, once the evidence is examined or reflect systemic failure to make visible and value midwifery work while over describing and valuing male dominated work.
316. The MOHLC experts, whose opinions have been explicitly adopted by the MOHLTC in its pleadings have made invisible the differences in working conditions, particularly one of the more profound job characteristics of midwives: that they are on-call 24/7 for their clients and work frequently long hours without sleep; travel alone at night; and enter buildings at night unaccompanied. The experts further contribute to the systemic gender discrimination by hypothesizing four main reasons to explain the wage gap:
 - a) Differences in education and scope of practice, even though these differences were already accounted for and factored into the analyses of Morton in 1993, Hay in 2004 and Courtyard in 2010;
 - b) Differences in bargaining strength, even though there is evidence that bargaining strength is subject to gender discrimination as described in the 2004 Canadian Pay Equity Task Force report, and yet the Ministry experts fail to provide a gender analysis of the bargaining strength of midwives;
 - c) Part-time work of midwives even though pay equity is not about annualized pay but about the pay rate; and, that there is evidence that part-time work is a gendered issue and yet the Ministry experts fail to provide a gender analysis of this factor;
 - d) A shortage of family physicians and the lack of substitutes for these physicians, although the government's documents will show that it was and is the government's plan to use midwives to substitute for the majority of family physicians who do not provide intrapartum care.
317. None of the MOHLTC expert reports contain a pay equity/human rights/job evaluation analysis of midwifery work and any male predominant comparator. The MOHLTC has had more than enough time to carry out such an analysis and the failure to produce one will be subject to a negative inference by the Tribunal

that such an analysis would not have supported the MOHLTC position that its compensation is gender equitable. It also appears that the Government considered whether to do a further report after Courtyard but considered that it might also come up with a similar equity adjustment result. (See Appendix 5)

318. Further the MOHLTC pleadings and expert reports are not consistent with what Government produced documents state occurred.
319. The MOHLTC has produced Cabinet documents and other Government documents relating to midwifery compensation setting, which confirm many of the factual statements and principles submitted by the AOM in its Application Schedule A and which also contradict many of the statements made by MOHLTC expert reports which purported to take a view on what might be the reason for the Government's decision to pay substantially more compensation to CHC physicians than to midwives and widen the gender pay gap.

b. Critique of MOHLTC Experts by Government Documents

320. Attached as Appendix 5 is a Chart that sets out excerpts from Government statements in these documents, which are relevant to the AOM claims and the MOHLTC defence.
321. For the Tribunal's assistance, the general topics addressed in these documents are set out immediately below. Under each topic are short, representative selections from Cabinet and other Government-authored or Government-considered documents. As indicated in Appendix 5, there are many more such statements in these documents which confirm the actual evidentiary basis for the decisions made by the Government in the course of its decision making on the education, funding framework and compensation setting for midwives.

A. Program Framework Document and Task Force Report as the foundation of the OMP

- *"The Program Quality Committee will monitor the implementation of the Ontario Midwifery Program to ensure that it proceeds in accordance with the principles inherent in the program framework document."*
(Cabinet Submission by MOH re: Ontario Midwifery Program Framework Document attaching documents re: Midwifery Model of Practice, Distribution of Midwives and Draft Terms of Reference of Midwifery Central Organization, September 1, 1993)

B Government control over the practice of midwifery

- *"However, the Ontario Midwifery Program was developed to fund and manage midwifery services as a program, rather than as a profession such*

as physicians and chiropractors. The program management approach allows for broader stakeholder input (specifically consumers). The CHB's aim was to build on the strong links between midwives and their consumers that characterized the process of regulating midwifery.

Program management also allows the ministry control over costs because midwifery services are funded through the TPA with a line-by-line budget. The ministry has control over where midwives will practise because it can fund agencies in areas of greatest need and the agencies can attract midwives without costly incentives."

(Midwifery — Questions and Answers attaching Midwifery — Possible Question and Facts of the Issue (dated July 29, 1997) and pages 2-6 of Areas of Concerns and Ministry Responses, August 1, 1997)

C. Alignment of CHC Physician compensation with other Primary Health Care providers

- *"The ministry, through the Community Health Unit, established salary ranges for all of the registered health professions it funds including physicians. These ranges are reviewed every few years to ensure they remain competitive with the compensation available to health providers working in different practice settings. This review involves the engagement of independent consultants with demonstrated expertise in conducting compensation reviews."*
(CHC Maternity and Other Benefits, March 3, 2006)

D. Public Demand and Shortage of Midwifery Services in Ontario

- *"Demand for midwifery services continues to exceed the supply of midwives. In addition to women who received midwifery services in 2009-10, midwifery practice groups reported that an estimated 7,950 women requested midwifery care but were unable to be accommodated."*
(2012-2013 Results-based Planning: Business Case – Midwifery Services)

E. Midwifery and female gender-incumbency/ association with women

- *"Midwifery is a female dominated profession focusing on women's health care during pregnancy and childbirth. The philosophy of midwifery, as stated by the Interim Regulatory Council of Midwifery, recognizes a woman as the central decision maker for her and her infant's health care. The curriculum content for midwifery includes aspects, of women's studies so that childbirth is understood in the wider context of societal and cultural traditions and values.. Midwives can contribute to a less medicalized model of health care and help restore an emphasis on normal childbearing.
A program with flexible entry criteria, assessment of prior learning and decentralized clinical and other program' arrangements can facilitate women's*

entry to midwifery education and provide new career opportunities.. (Note: This does not exclude men from entering the profession, but recognizes the likelihood that women will predominate).

(Cabinet Submission by the Ministry of Health and the Ministry of Colleges and University re: Midwifery Education in Ontario with Appendices, June 12, 1991)

F. Midwifery Services and engendering healthcare

- *"Several factors led to the decision to give legal recognition to midwifery. For some time, interest in midwifery had been growing in Ontario. Some women had come to believe that maternity care was overly controlled by the predominantly male medical profession - obstetricians who regard every pregnancy and birth as a potentially pathological event. [...]. Consumers reported feeling more in control and more part of the birth experience when they had a home birth. Many submitted that they felt by choosing home birth they were taking on the responsibility of the birth instead of abdicating it to others."*

(Cabinet Submission by the Ministry of Health and the Ministry of Colleges and University re: Midwifery Education in Ontario with Appendices, June 12, 1991)

G. MOH's views on expanding midwifery services

- *"The government has made a commitment to expand access to midwifery services in the province. This has included increasing the number of seats available in the MEP. In order to follow through with this commitment the ministry will need to find the funding necessary to support the planned growth of the profession."*

(2012-2013 Results-based Planning: Business Case – Midwifery Services)

H. Perceived risks of un-met funding for midwifery

- *"Significant public outcry will result should midwifery stakeholders perceive funding for new midwives to be threatened. Midwives and clients feel passionately about ensuring equitable access to publicly funded midwifery services and significant expectation on the part of consumers exists that the Ministry will support midwifery to continue to grow to meet demonstrated demand."*

(CHD015-0 Midwifery Services, December 23, 2005)

I. Cost-effectiveness of Midwifery Services

- *"Evidence shows that women who are low-risk for pregnancy related complications have caesarean sections at a higher rate (25%) when receiving physician-led hospital care, as compared to midwife-led home care (15%). Midwife led care has also been shown to significantly reduce the costs from additional interventions (e.g. epidurals and instrumental birth), benefiting the mother and baby as well as the health-care system with shorter lengths of stay in hospital and lower re-admission (or admission) rates."*
(2013-2014 Results-based Planning: Independent Health Facilities Business Case – Two New Birthing Centres)

J. Denial of Hospital Privileges to Midwives

- *"In 2007 and again in 2011, the Ministry conducted a survey of Midwifery Practice Groups to collect information on hospital integration. Both survey results confirmed that there are challenges related to the hospital integration of midwives in Ontario."*
(Minister's Office Foundation Briefing on OMP, presentation by MOHLTC, December 20, 2013)

K. Positive Clinical Outcomes of Midwifery

- *"Clinical outcomes are better for midwifery clients than low-risk women under the care of family physicians in Ontario (higher breastfeeding rates; lower C-section, forceps and episiotomy rates; shorter hospital stays and maternal/newborn hospital re-admission rates)."*
(From 2004-05 RBP - 2004-05 Results-based Plan: Midwifery Program funding increase request by the Ministry of Health, May 1, 2004)

L Ontario Medical Association's Influence on Midwifery

- *"The Ontario Medical Association and individual physicians will call on the government to increase funding for family physicians to offer obstetrical services rather than increased funding for expansion of midwifery."*
(Briefing Note on Approval for the Midwifery Program Evaluation Plan, attaching a briefing note on the Program Evaluation, January 30, 2003)

M. Goals & Objectives of the Ontario Midwifery Program

- *"Ontario Midwifery Program Objectives:*
- to improve maternal and child outcomes,

- *provide choice in maternity care through managed, community-based midwifery services,*
- *provide consumer involvement in the planning, delivery and evaluation of services,*
- *improving access to midwifery services across Ontario,*
- *increase access to obstetrical providers in Ontario;*
- *meet the need for midwifery services in Ontario,*
- *meet the need for obstetrical providers in Ontario; and*
- *provide an equitable funding mechanism that supports the integration of midwifery services into the funded health care system."*

(OMP Presentation on Midwifery and Maternity Care in Ontario, October 15, 2007)

N. MOHLTC's position re the AOM as the representative of midwives in negotiations

- *"Since the regulation of the Midwifery profession in 1994, the AOM has represented Ontario Registered Midwives in negotiations and discussions (including but not limited to compensation) with the ministry. The AOM is recognized by all Registered Midwives as their representative in negotiations with the ministry. The AOM has the history and continuity of information regarding previous negotiations with the ministry that will inform the negotiation process."*
(Ministry of Health and Long-Term Care Assistant Deputy Minister's Decision Note Ontario Midwifery Services: 2008 Compensation Negotiations, 2008)

O. Liability insurance treated as separately from compensation

- *"MPG funding is divided into the following budget categories:*
 - * Midwife compensation and operational expenditures;*
 - * Disbursement funding for travel, professional liability insurance and benefits;*
 - * Grants for office and clinical equipment, leasehold improvements and remote practice grants."*
- (OMP - Minister's Office Briefing - Misdated Slide Deck for D Matthews on AOM Negotiations, January 26, 2011)

P. Government commitment to increase midwifery compensation in line with other PHC providers

- *"Proceed with Phase 2 of the negotiation process including further work in collaboration with the AOM to compile the information required to make evidence-based decisions. The goal will be to optimize available resources to foster equitable access of midwifery services for women with low-risk pregnancies through:*
 - *Compensation and operational increases in line with other primary health care providers; [...]*(Key Points Submission to Cabinet Office on Negotiations between the Ministry of Health and Long-Term Care and Association of Ontario Midwives, January 20, 2009).
- *"That said, the Ministry does not advise that we undertake a second compensation review. There is merit to the claim that midwives deserve a significant increase after several years of either no or minimal compensation increases. A second review will not likely achieve a much lower recommend amount. A second report carries the risk of another 20% recommendation, with additional consulting costs. The government would face increasing pressure to address a second report with similar results as the first."*
(Ontario Midwifery Services Negotiations with the Association of Ontario Midwives Labour Relations Steering Committee, July 20, 2011)

Q. Demanding nature of workload and working conditions for Midwives as PHC providers

- *"Although there is no difficulty in recruiting midwives to the Midwifery Education Program, one of the reasons behind why many previously trained foreign midwives are not more attracted to practicing within the Ontario model is because of the demanding nature of the on-call schedule."*
(Options Paper: Expansion of Number of Midwives in Ontario (Draft), May 2, 2000)
- *"A key difference between the Ontario midwifery model and other international models is that the Midwifery Act, 1991 recognizes midwives as primary caregivers. This means that midwives in Ontario:*
 - *Take primary responsibility for low-risk obstetrical care in and out of the hospital in the absence of physicians,*
 - *Hold admitting and discharge privileges in hospital,*
 - *Consult directly with medical specialists,*
 - *Provide (24 hour) on-call care while providing antenatal care, intrapartum care and care to mothers and babies for 6 weeks postpartum,*
 - *Prescribe medications, conduct physical assessments, perform neonatal resuscitation and perform other authorized acts including episiotomy and suturing."*(Issue Note on the status of expanding the Midwifery Program and the self-sustainability of the CMO, May 2, 2002)

Part 18 AOM Remedial Relief Claims

a. Summary of Claims

322. Below text taken from AOM Application – Schedule A.

5. Losses and Relief Claimed

65. As a result of the above-noted unequal treatment, Ontario's registered midwives

(a) have incurred large economic pay losses and other damages requiring compensation and restitution (See Part 6 – Discriminatory Impact of Unequal Treatment).

(b) have suffered injury to their dignity, feelings and self-respect requiring further compensation (See Part 6 – Discriminatory Impact of Unequal Treatment).

(c) require public interest future compliance remedies to ensure such discrimination, losses and injury will not reoccur (See Part 8 – Remedies Sought for Past Discrimination and Future Compliance).

b. Monetary Compensation and Restitution/Damages

420. The applicant seeks the following monetary compensation on behalf of Ontario midwives:

(a) The Ministry shall pay to the complainant midwives retroactive compensation back to the date they would have been entitled to such compensation as if the Code had not been violated in order to rectify the unequal compensation they received.

(b) The Ministry shall also locate and pay to all midwives who performed midwifery services (and not just the complainant midwives) that were paid an inequitable rate compensation back to the date they would have been entitled to such compensation as if the Code had not been violated in order to rectify the unequal compensation they received.

323. The gender pay gap is based on the Durber evaluation over the period from 2013 back to 1994 and is based on looking at the salary of the CHC physician which was available to the AOM at that time. In that regard, the CHC physician is not required to pay for their liability insurance premium which is paid for by the MOHLTC. The midwifery premium is also paid by the MOHLTC.

324. The applicant, on behalf of the complainant midwives seeks all necessary remedies to ensure that midwives including those who retired from midwifery are made whole and a process is put in place to ensure midwives' ongoing compensation is free from sex-based discrimination contrary to the Human Rights Code.

c. Should the MOHLTC Pay Retroactive Compensation Adjustments

325. What is the impact of contracts being expired? The facts show that the AOM has clearly articulated the requirement for equitable compensation since the 1990's and has explicitly since November 2000 requested retroactive compensation, then requested back to 1994. (AOM claim now is back to January 1, 1997 which is the date Mr. Durber said that a pay equity adjustment was first owing as a result of the increased SERW on the part of the midwives who had now practised for three years. Ever since January 1, 1997, the MOHLTC has neglected to close the midwifery gender pay gap).
326. The facts as set out in the AOM Overview Summary show that the government has been well aware of the AOM's claims for equitable compensation with the first recorded claim for a specific equity adjustment happening in November, 2000.
327. Human rights principles encourage efforts to resolve disputes internally and collaboratively before pursuing adversarial litigation. Here the AOM engaged in the processes which the MOHLTC had set up - that is the discussions with the AOM which culminated in the JMAC Terms of Reference in 2010 and the MCFAC Terms of Reference in 2012 and participation in the Courtyard Compensation Review in 2010. (see AOM application, (pp. 68-98.) Both of these bodies were mandated to discuss disputes between the parties. Here the MOHLTC encouraged the AOM to resolve disputes internally. The MOHLTC was never under any illusion that the midwives were giving up any human rights claims as a result.
328. A November 2010, internal Ministry document addressing the negotiations with the AOM shows that the MOHLTC had identified a Human Rights Code risk and that they were still trying to address the issue in the negotiation process:

While not mentioned by AOM, there is an outside risk they could bring an equity issue forward under the Human Rights Code, but NPs are a female dominated group as well, and the argument to compare Midwives scope of practice to Obstetricians is not clear. Ontario Midwifery Program, Negotiations Branch, Update: November 8, 2010 p.4

329. The *Human Rights Code* Preamble makes it clear that it is "public policy in Ontario to recognize the dignity and worth of every person and to provide for equal rights and opportunities without discrimination that is contrary to law, and having as its aim the creation of a climate of understanding and mutual respect

for the dignity and worth of each person so that each person feels a part of the community and able to contribute fully to the development and well-being of the community and the Province.” This means encouraging the collaborative resolution of disputes.

330. The British Columbia Human Rights Tribunal in *Penner v. B.C. (Ministry of Public Safety and Solicitor General)*, 2005 BCHRT, 465 at para. 11 has noted the importance of encouraging the use of internal resolution processes before the intervention of Tribunal dispute resolution processes.
331. In this context, there is no basis for permitting the MOHLTC to delay and deny this human rights claim and then to argue it should not be responsible for rectifying it due to that delay. Otherwise, it would encourage respondents to get complainants to engage in such processes with the purpose of eliminating liability for each day they engaged in the process.
332. It is the midwives who have suffered the prejudice as a result of the delays by having to provide midwifery services for discriminatory pay.
333. The AOM acted with due diligence in pursuing the rights of midwives. It would frustrate the purpose of the Code to deny midwives access to Code retroactive compensation for the period prior to November 27, 2012 because they engaged in good faith efforts to resolve their claims.
334. As pleaded by AOM, even as late January, 2013 the Minister of Health and Long Term Care was advising the AOM that the MCFAC was the process where "conversations regarding fair compensation will take place." (Application, para. 353). At the MCFAC Negotiation meeting on April 29, 2013, Ministry ADM Fitzpatrick told the AOM with respect to their request for equitable pay "You're going to have to wait" (Application, para. 370). When that occurred the AOM proceeded to file its complaint within 6 months, once expert reports were obtained.
335. The MOHLTC is not immunized from Code compliance by securing the agreement of the AOM to funding contracts. In fact, it is improper to seek the agreement of a person to a discriminatory arrangement. It is well-established that the Code is for the general benefit of the community and its members and cannot be waived by a contract or collective agreement.¹¹³The MOHLTC cannot "contract out" of its obligation to pay compensation to midwives free of sex-based discrimination.
336. This is clearly demonstrated in the context of the *Pay Equity Act* where the Divisional Court in *Re Ontario Northland (J.R.) (1993)*, 4 P.E.R. 19, 1993 CanLII 5424 affirmed that there is no right to contract out in collective agreements from

113 See *Ontario Human Rights Commission v. Etobicoke* [1982], 1 SCR 202 and *Steve Vitricek v. 642518 Canada Inc. (Algonquin Careers Academy)* and *Des Soye* 2010 HRTO 757 Can LII.

pay Equity Act obligations. Employers remain liable under the Pay Equity Act for pay equity adjustments regardless of whether a collective agreement was signed with the bargaining agent agreeing to wages which are not pay equity compliant.

337. In considering the issue of retroactive compensation, it is important to consider that the MOHLTC had a proactive obligation since 1994 to make visible and value the work of midwives and ensure that their compensation was free of systemic gender discrimination in compensation. This required the MOHLTC over the years since 1994 to do compensation analysis and comparisons and to consider if its practices were causing systemic gender discrimination. That included keeping records and documentation with respect to the work and at least the comparators which were originally used in the Morton report.
338. Given the Ministry's ongoing failure to promptly and properly investigate the AOM's claim that its compensation funding for midwives and its processes and mechanisms for negotiations is inequitable and to have in place a pay equity compliance mechanism, the Ministry should be required to make the necessary retroactive payments to put the midwives in the position that they would have been if the Ministry had properly considered the human rights allegation at the time and taken the necessary corrective action.
339. The Ministry's failure to investigate and address the complaint also exacerbated the injury to dignity, feelings and self-respect experienced by midwives, thus warranting additional compensation.

d. Claim for Injury to Dignity Feelings and Self-Respect Compensation

340. The applicant seeks that the Ministry shall pay to the complainant midwives appropriate compensation commensurate with the significant, persistent and ongoing injury to their dignity, feelings and self-respect arising from the above-noted Code violations.
341. The midwives have experienced prolonged injury to their dignity, feelings and self-respect as a result of the serious and persistent Ministry conduct detailed in this application, which resulted in midwives being underpaid for their services because of their gender, the gender of their clients and the gendered nature of their work. The effects experienced by the complainant midwives are particularly serious and include the following: humiliation, hurt feelings, loss of self-respect and confidence; loss of dignity; loss of self-esteem; loss of confidence; the experience of victimization and vulnerability.

342. The evidence of this is set out clearly in the AOM witness statements from six midwives, which are representative examples of the injuries to dignity, feelings and self-respect that the complainant midwives have suffered.¹¹⁴
343. This is particularly true for midwives who make family and personal sacrifices because of demanding on-call responsibilities.
344. The complainants are alleging human rights violations which meet the criteria for the Tribunal awarding a substantial injury to dignity remedy:
345. Some complainants have suffered from pay discrimination since 1997.

e. Claim for Interest

346. The applicant seeks that the Ministry shall pay pre-decision interest on all monies owing as set out above up to the date of decision, calculated in accordance with section 128 of the *Courts of Justice Act*, R.S.O.1990, c.43 and the *Hallowell House Limited* [1980] OLRB Rep. January 35 decision principles.
347. The Ministry shall pay post-decision interest on any accumulated principal and interest calculated in accordance with section 129 of the *Courts of Justice Act* and the *Hallowell* principles.

f. What Needs to Be Done to Ensure the Gap, Once Closed Does not Reappear and Future Compensation Setting is Equitable

348. The AOM has requested the following remedies to ensure future compliance with the Code
 - (a) To prevent similar discrimination from happening in the future, the applicant seeks the following:
 - (i) The Ministry will set the compensation/fees for midwives in accordance with the Code and the analysis provided by experts Paul Durber and Hugh Mackenzie.
 - (ii) The Ministry will set up and follow an equitable compensation bargaining structure for the AOM for midwives similar to the one provided to the OMA by the MOHLTC.
 - (iii) The Ministry will establish regular pay equity evaluation processes with the government accountable for implementing the results and subject to review and monitoring by an independent third party with expertise in pay equity and approved by the applicant and Tribunal. Where agreement cannot be reached, adjudication of the

114 Statements of Maureen Silverman, RM, Rebecca Carson, RM, ,Daya Lye, RM, Jackie Whitehead, RM,Nicole Roach, RM, Tracy Pearce-Kelly, RM

necessary pay equity compliant compensation will be made by such third party. All such third party fees and costs to be paid by the Ministry.

- (iv) The Ministry will adopt and implement a sex- and gender-based analysis approach to the setting of midwifery compensation and other compensation it funds which is not covered by the *Pay Equity Act*
- (v) Ministry staff will complete the Ontario Human Rights Commission's online training Human Rights 101 (available at www.ohrc.on.ca/hr101) or equivalent training on basic principles of human rights and confirming to the applicant's counsel that this has been done within 60 days of the decision.
- (vi) The Ministry will retain a human rights expert agreeable to the applicant and the Tribunal who will:
 - (1) Assist with the review and revision of the Ministry's compensation funding and bargaining policies and that a revised policies will be distributed to appropriate Ministry employees.
 - (2) Train MOHLTC employees up to the Deputy Minister involved in the setting of midwifery compensation with respect to the revised policy, the Code and how to provide achieve and maintain pay equity.
 - (3) Similarly train Ministry of Finance employees who handle midwifery funding.
- (vii) The Ministry will communicate to all appropriate Ministry staff, to Ministry of Finance staff, to midwifery Transfer Payment Agencies and to appropriate health care professional stakeholders who work with midwives a summary of the decision of the Tribunal, such summary to be approved by the applicant and the Tribunal.

349. The AOM reserves the right to claim other public interest relief should the evidence require further action to ensure the discrimination will not reoccur.

Part 19 The Parties' Ongoing Documentary Disclosure

350. The parties have disclosed to each other arguably relevant documents and documents that that they intend to rely on, in accordance with the rules prescribed in the *Code*.

351. The parties also continue to make ongoing disclosure of arguably relevant documents and documents to rely on to one another.

352. As the MOHLTC disclosure is not finished, the AOM is not yet able to conclude that it has received all necessary documentation flowing from its June, 2014 Request for Production and further requests for documents may be necessary. The AOM will be working with the MOHLTC to ensure all necessary information is put before the Tribunal.
353. The AOM also has certain MOHLTC requests for documentation which it is following up on.
354. The parties have generally agreed that the documents exchanged as documents to rely upon to date are authentic. "Authentic" means, to the extent applicable to any particular document, that in the absence of any reliable indicator to the contrary:
 - (a) The document was authored by the person or entity by whom it appears to have been authored;
 - (b) The document is a true copy of the original document and was printed or signed as it purports to have been;
 - (c) The document was made on or about the date it appears to have been made or was sent on or about the date it appears to have been sent and was received within a reasonable period of time after its date; and
 - (d) The document was received by the person or entity to which it appears it was sent.
355. As an overriding principle, the parties remain committed to reasonable flexibility with respect to the documentation and have generally agreed that counsel may challenge the authenticity of a document if it becomes apparent during the hearing that one or more of the elements of authenticity described above should not be admitted with respect to a particular document, and counsel are permitted to withdraw an admission of authenticity at that time.
356. At the current moment, the parties are considering how to adapt their initial views on the authentication and presentation of document to the currently proposed process by which various documents will be introduced through a witness affidavit.
357. The parties are committed to continue their collaborative approach to the presentation and management of the documents in this case.

