



## **Ontario Midwives Application to the Human Rights Tribunal of Ontario:**

### **A Summary**

#### **Introduction**

On November 27, 2013, the Association of Ontario Midwives filed an application with the Human Rights Tribunal of Ontario on behalf of the province's midwives. The application outlines the ways that the Ministry of Health and Long-Term Care, over nearly 20 years, continually and systematically set a discriminatory compensation structure for midwives. This inequitable compensation robs midwives of basic pay equity—the right to be free from sex-based discrimination in compensation. Pay equity is a fundamental human right guaranteed by the *Human Rights Code* and the *Pay Equity Act*. Those responsible for setting the compensation of women's work, like the Ministry in this case, are required to take all necessary steps to evaluate the women's work in relation to appropriate male-dominated work and ensure that compensation is equitable.

Midwifery is the most exclusively female-dominated profession in Ontario. One male midwife was licensed in 2012; in the 20-year history of regulated midwifery in this province, only one other man has become a registered midwife (less than 1% of the profession). Midwife literally means “with woman.” The model of midwifery care provides a specifically gendered kind of health care to women. In other words, it is work by women, for women, as it relates to women's health. Together, this has resulted in a gender penalty for midwives: a deep discount in their pay.

Expert reports by pay equity expert Paul Durber and economist Hugh Mackenzie have identified pay equity gaps since regulation and specifically starting in 1997 to the present. Currently, Durber, as a result of a detailed pay equity analysis under the Gender Equitable Job Evaluation Factor Plan, found that midwives should be paid 91% of the pay of the Community Health Centre (CHC) family physician. Instead they are being paid about 52% of what their work is valued at. As a result, there is currently a pay gap of approximately \$94,800.

A midwife is a trained, regulated, primary health care provider, licensed by the College of Midwives of Ontario. In the course of caring for a woman during her pregnancy, birth and the six-week period after the birth, a midwife provides a range of health-care services. Midwives continually assess the health of both the woman and the baby during the prenatal period by monitoring blood pressure, assessing fetal heart rate, measuring fetal growth, interpreting lab results such as ultrasounds, blood and genetic tests and prescribing medications such as antibiotics. They answer a woman's questions, assess her risks (including physical risks such as gestational diabetes, as well as social risks, such as domestic abuse), and learn about her family. During the labour and birth, they provide continuous care by monitoring fetal heart rates, the mother's vital signs and the progress of labour and assessment and repair of perineal laceration.

Midwives are constantly vigilant to potential signs of complications or danger. Midwives, who are recertified regularly in managing emergencies, make critical judgment calls that save lives in situations such as shoulder dystocia, hemorrhage and decreased fetal heart rates. In the six-week postpartum period, midwives monitor mothers for blood loss, postpartum depression, recovery of the perineal and anal areas, signs of infection and breast health. They monitor newborn infants for heart abnormalities, breathing difficulties, physical and developmental anomalies, appropriate levels of growth and ability to feed and obtain capillary blood samples for routine screening. After four years of rigorous university-level education and a supervised postgraduate year, a midwife is a specialist in normal pregnancy and birth.

## **Background**

The health-care system itself, and the professions that comprise it, are sex stratified. The professions of midwifery and nursing, for example, are heavily female-dominated; although more and more women have been steadily joining the physician ranks, that profession remains male-dominated and benefits from its many years of being male-dominated. From 1885, when practicing midwifery became “alegal” (neither legal nor illegal), to 1994 (the point at which midwifery was regulated), pregnancy and childbirth became “medicalized.” It was seen as an experience best managed by the male-dominated profession of physicians.

After many years of organizing and advocacy, the government convened a Task Force on the Implementation of Midwifery in Ontario in 1986. The Task Force released an extensive, detailed report in 1987, providing government with a number of recommendations regarding establishing midwifery as a regulated health profession. These included guidance around midwifery education, integration into hospitals, relationships with stakeholders and ensuring equitable compensation.

In 1991, the Ontario government passed the *Midwifery Act*. Amendments were made to the *Public Hospitals Act* that allowed midwives to admit, discharge and write hospital orders. And yet, a number of barriers to full hospital integration of midwives remain: midwives are excluded from decision-making bodies such as the Medical Advisory Committee, they function as head midwives almost always without compensation (unlike Chief positions, which are paid roles), and in many cases are prevented from providing care within their full, licensed scope of practice.

In 1993, when the Ministry of Health was setting the compensation level for what would become a newly regulated profession, a pay equity-informed analysis was undertaken that considered the skill, effort, responsibility and working conditions of an entry-level midwife. This analysis was conducted by a consultant hired by the Ministry of Health, Robert Morton. Although it was not a robust pay equity exercise, the analysis determined that the rate of pay

for this newly regulated health profession should fall slightly below that of the male-dominated Community Health Centre family physician but above that of the female-dominated CHC primary care nurse (now referred to as a nurse practitioner). The analysis omitted a number of features of midwifery work, as the profession had not yet begun to work under regulation, which started as of January 1, 1994.

Just prior to the regulation of midwifery, the government established the Ontario Midwifery Program, the branch of the Ministry of Health that was tasked with managing and funding midwifery services. A midwifery funding framework was established, based on the recommendations of the Morton Report (which also considered market factors, in addition to the preliminary pay equity analysis). The Ministry adopted the Morton Report's recommendations and also agreed to make the recommended annual cost of living adjustments.

Once midwives started to work under regulation in 1994, the Ministry stopped engaging in any pay equity analysis; as a result, very substantial pay equity gaps started to appear as of 1997. Since 1994, the skills, effort, responsibility and working conditions of midwives have increased. Yet the Ministry has made no effort to put in place a proper pay equity analysis to ensure that midwives were and are being paid in the proper proportion to their male comparator, the CHC physician.

Midwives were originally understood to be dependent contractors—controlling their own businesses, but dependent on one source of remuneration for their services, which is the Ministry of Health. By 1999, government shifted the status of midwives to that of independent contractors, as this title was thought to better reflect the model of practice, the autonomy of midwives and the demands of their 24/7 hours of work. However, this title did not accurately reflect how much midwives are, in fact, constrained like employees in their work and compensation. For example, a midwife's caseload (the volume of women she cares for in a year) must be approved by the government-appointed transfer payment agency and the Ministry of Health.

Midwifery has proven to be a safe, high-quality, cost-effective health-care service that has always been in line with primary care system reforms. And yet:

- The Ministry froze the compensation of Midwives for an 11 year period (1994 – 2005) and another three-year period (2011 – present) in which zero compensation increases took place.
- During that period of time, the CHC family physician (which had been the midwifery comparator) received substantial compensation increases.
- The Ministry did not take proactive steps since 1994 to ensure that the pay equity analysis undertaken was maintained.

- The Ministry permitted the pay equity gap to widen and then continually argued that it was too costly to close it.

### **Development of Post-Regulatory Pay Inequity**

The unequal treatment of midwives is contrasted sharply with the male-dominated profession of physicians, which is particularly reflected in the differences between the Ministry's ongoing relationship with the female-dominated Association of Ontario Midwives (AOM) and that of the male-dominated Ontario Medical Association (OMA).

From 1994 to 2005, the Ministry failed to negotiate a compensation increase with midwives. This, in spite of the fact that, in accordance with the original pay equity-informed analysis, midwifery compensation should have proportionately kept pace with physician compensation. A compensation increase was secured for midwives in 2005 and 2008, covering small yearly increases to 2011. But in that same time period, the Ministry reached six agreements with the OMA, each of which increased compensation (except the last one, which included a decrease). While CHC family physicians also had their pay frozen for a period of time, as of 2003, their compensation started to increase substantially.

Moreover, midwives have never received the yearly cost-of-living increases as outlined in the original Ontario Midwifery Funding Framework. In 2003, the AOM hired a consultant to undertake a compensation review of midwifery, which found midwives worked longer hours, received lower benefits, lower on-call fees and lower compensation than the original two comparator groups. The Ministry of Health provided no formal response to the report. In 2005, the Ministry did announce a one-time, 20% increase to midwifery compensation, which was intended to make up for some of the pay equity gap that had grown. Yet the AOM's economic expert, Hugh Mackenzie, has found that this increase basically just adjusted the midwives' compensation to where it should have been if cost of living adjustments had been provided. The Ministry continued to fail to undertake a pay equity analysis. As a result, midwives still faced a large pay equity gap between their pay and that of the male-dominated CHC physicians.

Negotiations between the Ministry and the AOM were scheduled to begin again in 2008. However, the Ministry advised the AOM that it needed to delay meetings as the result of a major organizational change at the Ministry. And yet, the Ministry went ahead with negotiations with the OMA, resulting in substantial increases for CHC physicians. By the time meetings with the AOM were held, the Ministry advised that due to the global economic instability, midwives would be subject to compensation restraint policies (which were not applied equally to other health professionals).

Negotiations concluded in 2009 with minimal compensation increases, in spite of the evidence of midwives producing excellent health outcomes with very high client satisfaction rates, and a widening pay equity gap. In spring 2010, government introduced legislation intended to freeze the compensation of public employees. In spite of the fact that midwives were not employees, government informed the AOM that midwives would be subject to this legislation. The next round of negotiations began in fall 2010 for the contract that was due to expire March 31, 2011. The Ministry hired the Courtyard Group to undertake a compensation review. That report was released that fall, and, while not a proper pay equity analysis, recommended a one-time equity adjustment of 20%. Government rejected the report's findings without providing a formal or written response. This was in spite of the report's findings that health outcomes for mothers and babies cared for by midwives are better than the provincial average for low-risk mothers.

The years 2011 and 2012 were marked by meetings that led to no concrete efforts on the part of the Ministry to address either the pay equity gap or simple cost-of-living increases, as well as a series of cancelled meetings. At the same time that the Ministry delayed addressing the pay equity gap, government continued to agree to compensation contracts that gave large increases to male-dominated positions, such as correctional services officers and the OPP.

### **Current Status**

Almost two years passed—from May 2011 to April 2013—before negotiations were held again between the Ministry and the AOM. In spite of the repeated and constant efforts of the Association, the Ministry has simply refused to negotiate the midwifery contract. And in the meantime, other professional associations—including the Ontario Medical Association—negotiated contracts in an appropriate, timely manner. Midwives, on the other hand, fell even further behind.

In April 2013, government gave the AOM a “take it or leave it offer,” which included no plan to address pay equity. In order to be able to continue to provide care to pregnant clients, midwives agreed to accept this offer while telling the government that, in doing so, they would be pursuing a legal challenge to the failure to provide pay equity compliant compensation. Midwives then voted to initiate a human rights application against government, to begin to address the 20-year history of neglect. In September 2013, the AOM was informed by government that the Ministry would no longer be negotiating the midwifery contract with the AOM. The status of contract negotiations, and the problem of midwives being further disenfranchised from the negotiations process, remains unclear.