



Association of
Ontario **Midwives**
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Ontario Midwives on Closing the Gender Pay Gap

Submission to the
Gender Wage Gap Strategy Steering Committee

January 15, 2016

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Gender Wage Gap Strategy Steering Committee
400 University Avenue, 12th floor
Toronto, Ontario
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Dear Committee Members,

Re: Closing the Gender Pay Gap in Ontario

Thank you for the opportunity to provide this submission on behalf of the Association of Ontario Midwives (AOM); it is in addition to our members' submissions at the Town Hall meetings across the province.

In the Town Hall meetings, midwives from across Ontario spoke to you about their deep commitment to the struggle for equity in pay not only for themselves, but for all Ontarians. They have not only experienced the prejudices and economic impacts of such inequities in their own lives, but have also seen how such gender inequities play out in the lives of their female clients and families.

In Ontario, midwifery is the most predominantly female profession among primary health-care providers, which provides women's¹ health care during pregnancy and childbirth and newborn care to six weeks. The work of midwives is typified by three integrated factors relating to sex and gender: work by women, for women and as it relates to women's health. Midwives support the work of this Committee and are willing to work with the government to turn the intent into action and close the wage gap.

We recommend that the following be reflected in the Committee's Gender Wage Gap Strategy:

1. Include independent contractors and other workers who fall outside of traditional employment relationships in the provincial Wage Gap Strategy (The Strategy) and the measures taken to implement it.

¹ Note: midwives may be transgender and may care for a transgender person. Transgender people are also subject to forms of discrimination.

2. Implement mandatory gender-based analysis and planning at all levels of government including scenarios where the government is the funder. This includes short- and long-term plans, goals, targets, training for those who are involved in setting compensation, and monitoring results.
3. Develop a rights-based understanding and discourse of pay equity, and mandatory gender-based analysis and planning to prevent and redress systemic discrimination.
4. Give high priority in the Gender Wage Gap Strategy to health-care sector workers, who are likely to experience “the caring dilemma”.

Introduction

The AOM is the professional organization representing registered and Aboriginal midwives and the practice of midwifery in Ontario. Midwives provide health care during pregnancy and childbirth, and newborn care to six weeks. Midwifery in Ontario is an almost exclusively female profession. Of the approximately 800 midwives currently practicing in Ontario, only one is male. Like other female-dominated professions, midwifery has been and continues to be profoundly undervalued. Ontario midwives still earn far less than their counterparts in male-dominated professions who provide comparable services. While the gender wage gap in Ontario is 31.5 per cent on average, midwives are paid only 52 per cent of what their work is worth.²

As a member of the Equal Pay Coalition, the AOM also supports and relies upon the submission of the Coalition and its requests that the Committee release its consultation summary and options it is considering. This will permit the stakeholders to continue with the Committee and governments the necessary dialogue to create an effective and sustainable strategy to close Ontario’s gender pay gap by 2025.

² Durber P, Examining the Issue of Equitable Compensation for Ontario’s Midwives. Nov. 2013.

1. Pay Equity for Independent Contractors and Non-Traditional Workers

Independent contractors and other non-traditional workers must be included in the government's gender Wage Gap Strategy. The *spirit* of the Pay Equity Act (PEA) has to be applied to non-employees such as independent contractors as the spirit is intended to address a fundamental human right, a right that should not be denied to independent contractors or non-traditional workers.

For example, midwives are independent contractors in order to meet primary health-care needs during pregnancy, labour and birth. The midwifery model of care prioritizes and is responsive to the health-care needs of women. Since 1994, the work of a registered midwife has been defined in Ontario by the *Regulated Health Professions Act (RHPA)*, the *Midwifery Act* and the Ministry of Health and Long-Term Care (MOHLTC) through its funding contracts. The College of Midwives of Ontario (CMO) defines the midwifery model of care, which requires midwives to provide continuity of care to their clients. This requirement means that midwives are on call for their clients 24/7 and may provide services to women for long periods of time. Often the work of a midwife is difficult to schedule as it is dictated by the health needs of the client, the client's pregnancy, the timing and duration of the labour and birth (both of which are unpredictable), and the needs of the newborn. Therefore, since midwives were first regulated, they have been engaged in non-standard employment. To protect this model of care and, at the same time, not put midwives into a position where they would be breaching the *Employment Standards Act*, the Ministry of Health determined that midwives would work in practice groups, like physicians do, as independent contractors.

Midwives' commitment to caring for women throughout labour and delivery should not come at the cost of their right to pay equity and meaningful legal protection in the workplace. The singular reason why midwives were set up as independent contractors was to support a model of care that assures access to, and protection of, continuity of care by a midwife for clients. That is, the independent contractor model is *for the benefit of the recipient* of midwifery care, and not the midwife. When midwives agreed to this employment model, they did not agree to give away their human right to pay equity.

Yet their status as independent contractors has meant that midwives are excluded from the PEA and the rights and protections accorded to those in traditional employment relationships. The objective of the PEA—to correct systemic discrimination in compensation for female job classes—must be realized for all workers, regardless of their status. The Strategy must look beyond traditional employees, to embrace and account for the specific needs of independent contractors and non-traditional workers. These are precisely the workers whose positions are most precarious, and who are most in need of protection against gender-based discrimination in

pay. If members of predominantly female job classes continue to be excluded from the pay equity regime, Ontario will fail to protect its most vulnerable workers.

Furthermore, women in part-time, self-employed and non-traditional work cannot be ignored from the philosophies, practices and legislative protections of the PEA:

One of the most important features of nonstandard work is that it is heavily gendered along some dimensions. Females comprise the overwhelming majority of part-time workers (at about 70 percent) and, while they now comprise only about one-third of all self-employed workers, the proportion of females among the self-employed has steadily increased over the past three decades (see Figure 5). Further, while women occupy about 40 percent of full-time temporary jobs, they take up roughly 60 percent of part-time temporary jobs. The sex dimension of nonstandard employment is important given an overall economic context in which women experience lower average earnings in the labour market.³

The Strategy must acknowledge that workers who have less than full-time hours are particularly vulnerable to systemic gender wage discrimination. This can include both low and higher wage earners^{4,5,6} It is necessary to understand the history of women's work and pay

³ Chaykowski, R. Non-Standard Work and Economic Vulnerability, March 2005, P. 11.

⁴ This occurs for example in the profession of medicine where differences in wages between men and women physicians are explained by the part time "choices" that women physicians make. "The message conveyed by much of the coverage and commentary implied that female physicians simply do not work as hard as their male colleagues. These reports seem to be telling Canadians "if you're having trouble finding a physician, a large part of the blame lies with the increasing number of female doctors in the system." CMAJ March 11, 2008 vol. 178 no. 6 "Ending the sexist blame game" C Herbert et al.

⁵ "One of the key causes of the continuing gender wage gap is that our workplaces and our social and labour market policies have failed to reflect the realities of women's' lives. Today, the great majority of women, including mothers of young children and women with elderly parents, participate in the paid work force. But working women still take on most of the responsibility for care and for work in the home. Many employers demand very long hours of full-time workers, fail to provide reasonable and stable work schedules which match family needs, and will penalize women who take temporary leaves. As a result, many women are forced to work in lower paid and more unstable part-time jobs, or pay a big price for dropping out of the workforce for a year or two, or decide to work very long hours and not to have children at all."

<http://www.canadianlabour.ca/sites/default/files/pdfs/womensequalityreportEn.pdf>; Women in the Workforce: Still a Long Way from Equalit; Cdn Labour Congress, P.2

⁶ "Female physicians in general, and female family practitioners specifically, continue to maintain a different set of unpaid work and family responsibilities than their male counterparts. One recent study found that female family doctors who have children work more than 90 hours per week if unwaged household responsibilities are included. This was considerably more than the fewer than 70 hours worked by male family doctors who have children. Another study reported that the reduction in work time caused by having children under the age of 18 is twice as large for women as it is for men. Female family physicians are also more likely to be involved in the care of elder family members." Sex, lies and physician supply", Lindsay Hedden and Morris Barer,

equity to understand that a woman's decision to work part-time so that she can care for young children, or an aging parent is not a "personal choice" but rather is a social issue, informed by gender roles and stereotypes, and by public policy priorities that have been mostly shaped by men. To ignore this and to point to part-time work and blame the woman for this loss of income is a perpetuation of sexist stereotypes that women have complete choice over these circumstances that are in fact shaped by societal sexist biases and gender role stereotypes.⁷

Whether or not a female worker is in traditional employment, an independent contractor or in non-traditional work, gender always matters in dealing with women's work and its compensation, and therefore these workers must be protected from gender wage discrimination.

The AOM provided a submission to the Ontario government in 2015 regarding possible changes to the Labour Relations Act (LRA). We strongly recommended then, and reiterate now, that any changes to the LRA take into consideration how current legal frameworks for bargaining may in fact reinforce gender discrimination in pay. In 2004, the Canadian Pay Equity Task Force noted bargaining strength and structures as one of the reasons for gender based wage inequities:

An analysis of labour relations indicates that, in many cases, bargaining units are established in such a way as to reproduce gender-based occupational segregation. Thus, some certification units or unions represent female jobs (clerical workers, nurses, teachers) while others represent male jobs (trades, technicians).

Historically, predominantly female unions have been unable to exercise enough bargaining power to make progress in terms of pay and non-wage benefits comparable to those of male jobs. ... The analysis identifies gender-segregated patterns of union representation and bargaining as the major obstacle to be overcome. Collective bargaining "as usual" continues to produce low pay for traditional women's work, in large part because women are often isolated in bargaining units that are predominantly female. Labour law and practice make it all but impossible for workers in women-dominated bargaining units to negotiate in tandem with those performing work of equal value in male-dominated bargaining units. [...] Traditional union notions of community of interest and fair comparisons perpetuate rather than challenge gender-based systems of wage determination that disadvantage women. Given job segregation by gender, union bargaining strategies designed to achieve fair pay (for example, "pay the job, not the worker" and across-the-board wage increases) narrow but do not eliminate the gender gap in pay.

<http://umanitoba.ca/outreach/evidencenetwork/archives/19860#sthash.7sOAYqVJ.dpuf> (no date of publication given)

⁷ A. Kessler-Harris, *A woman's wage*, 1990, p. 119.

Moreover, union density is lower for female workers than for male workers in the private sector (13.0% versus 21.9%), and the jobs of many non-unionized female workers are precarious. Both factors combined reduce their bargaining power significantly....Many forms of non-standard employment are also less likely to be covered by a collective agreement and hence less likely to be afforded the degree of "protection" that is often provided by unions and collective bargaining.

The factors presented above interact and lead to inequity that can be described as systemic. In other words, in a given enterprise, female jobs bear the detrimental effects of the invisibility of certain female job requirements due to prejudices and stereotypes, traditional value determination methods, and pay practices that reproduce market inequities. The relatively lower bargaining power of female workers cannot counter these effects. In fact, the purpose of pay equity is to overcome the effect of such factors, in particular through non-sexist value determination methods and pay practices

The Canadian Pay Equity Task Force 2004 noted bargaining strength as one of the reasons for gender based wage inequities but argued that should not serve as an excuse for lack of access to equity:

It should not be forgotten that one of the reasons for the emergence of human rights legislation was the vulnerability of the groups whose rights are protected. Putting pay equity on the bargaining table along with many other bargaining priorities means exposing the rights of groups defined as vulnerable in a process where there may be significant pressure to compromise or withdraw, or to yield to the forcefulness of other participants in the bargaining. It is possible, of course, to formulate labour legislation in a manner which would protect the integrity of claims for pay equity. However, assigning pay equity to that legislative category in which fundamental human rights have been addressed would make clear that this issue should not be subject to the same kinds of pressures which attend other bargaining issues.⁸

We recommend that the Wage Gap Strategy include a review of the LRA to determine how it can be amended to eliminate the structural barriers that women have to bargaining.

2. Human Rights and a Gender-Based Analysis

It is crucial for government, businesses and society to start treating the right to equity in pay as the *human right* that it is. A woman's right to be free from sex discrimination in work and pay is her entitlement in Ontario under both the PEA and the Code. The legal protections of the Code and PEA *must* be upheld and enforced. This is not negotiable.

⁸ The Canadian Pay Equity Task Force 2004, http://ywcacanada.ca/data/research_docs/0000052.pdf, p. 148.

The Strategy must engage with and reflect the human rights framework that already exists in Ontario. This requires changing the language around pay equity. It is not women's *choice* to fall into the pay gap and it is not the government or employer's *choice* whether to close it. Rather, pay equity is a right and an obligation. It also requires implementing mandatory gender-based analysis and planning within government. This includes setting short- and long-term plans, goals, and targets as well as monitoring results.⁹ Government must also ensure that when the government itself establishes compensation and funding mechanisms, the structure is free of systemic discrimination under the Code provisions. Such mechanisms must ensure that those responsible to set the pay have proactive obligations to achieve and maintain pay equity in a manner which is appropriate to the particular work and consistent with the applicable principles of pay equity found in the PEA.

For midwives specifically, it is essential that government ensure that compensation and funding for midwifery services are compliant with the Code. The Ministry of Health and Long-Term Care (MOHTLC) sets the compensation of midwives and funding of midwifery services as a part of its delivery of the Ontario Midwifery Program (OMP). The OMP is designed to, among other things, provide "an equitable funding mechanism that supports the integration of midwifery services into the health care system."¹⁰ Midwifery services and the empowerment of women and their health-care choices through midwifery are a key part of the MOHTLC's women's health strategy. Funding and compensation for midwifery services must be determined through an evidence-based process that properly takes into account the skill, effort, responsibilities and working conditions of midwives relative to their counterparts in other health professions, as well as the value of midwifery services to Ontario and Ontarians.

Closing the gender wage gap for Ontario women is well-established public policy. Investing in women's talents and skills is an essential part of this government's plan to Build Up Ontario and foster a fair and equitable society with strong health care. In relation to midwives, the government has an opportunity to apply public policy and legal principles to a large, established group of predominantly female professionals with whom it has a long-term working and funding relationship. By implementing an equitable structure and ensuring Code compliance in the compensation of midwives, and ensuring that all public service employees who are involved in a compensation process are trained to recognize how to apply a gender analysis on all compensation decisions. The government can lead by example. Promoting pay equity in health-care strategies, policies and programs is a key element in transforming the health-care system—one of the most valuable sectors in Ontario.

⁹ Cornish M, Taking Action TO Close Ontario's Gender Pay Gap-Planning for Gender equality by 2025. Presented at the Ryerson Centre for Labour Management Relations Conference on the "The case for Pay Equity: Exploring the Benefits and Models That Work." Sept. 2015.

¹⁰ Ontario Midwifery Program Guidelines, May 1999.

3. Redressing Systemic Discrimination

It is evident from women's narratives at the Wage Gap Strategy Town Hall meetings that women across the economic spectrum have historically and presently face discrimination in work and pay. It is clear that women know there is an issue and would like the government, employers and society to address it. Women are aware that they have been wronged but not sure how to access legal recourse. The experience of midwives illustrates that it takes significant commitment, resources and time to pursue legal action to protect a fundamental human right. Opting for the legal remedies may not be an option for everyone but women need to know that options are available and what acts or omission are a breach of the Code. Currently awareness around the Code is focused on the social areas and grounds in relation to individual incidents of discrimination, which is essential to how it operates and can be enforced. An objective of the Code is to address systemic discrimination, its use in this area has been limited especially in relation to the ground of sex. Part of the Wage Gap Strategy needs to focus on awareness of the objectives of the PEA and the Code, and how remedies can be accessed.

4. Workers who Experience the "Caring Dilemma"

Health care is highly segregated across gender lines¹¹ and this has a large impact on the inequities in compensation for health-care workers. Midwives for example are conflicted about asserting their right to pay equity *if* it would impact the right of women to access midwifery care. This dynamic is known as the "caring dilemma."

Dr. Pat Armstrong has written extensively about the gendered hierarchies in medicine that underlie the "caring dilemma."

There is a notion that support work in health care requires few skills, a notion that reflects both the female dominance of health care work and the traditional male dominance of medicine. It does not reflect the literature on the determinants of health or the feminist literature on skills (see, for example, Armstrong 2013b; Gaskell 1986). Medical men played a key role in the development of the Canadian health care system. Their model of practice stressed the intervention through surgery and drugs, or what is called allopathic medicine. In this model, doctors are scientists who base their treatment of body parts on the specialized knowledge of causes and cures. Their dominance is both justified and required in order to ensure effective diagnosis, treatment and cure (Armstrong and Armstrong 2003: ch. 2). These men and their model shaped the development of formal care systems. While women have continued to provide the majority of daily care, the

¹¹ Health Force Ontario, 2012

*doctors have long been in charge. Health care was and remains highly gendered and characterized by segregation in terms of occupations and by fundamental inequalities in power.*¹²

The Wage Gap Strategy should assure that the value female health-care providers bring to the health care and social services systems are appropriately acknowledge by a proper pay analysis and compensation that reflects the value of their work; and we recommend that the health-care sector be a priority area in the Strategy.

Conclusion

Ontario midwives believe now is the time for the Ontario government to take the lead in closing the pay gap by implementing a strong pay gap strategy that focuses on action and enforcement of the law. Midwives are an illustration of a highly female-dominated profession in a non-traditional working relationship working for women's health care and, as a result, their work has been historically and is currently undervalued. We strongly recommend that the Gender Wage Gap Strategy looks beyond the traditional employee and focuses on the independent contractor, precarious, and non-traditional workers who need access to pay equity the most. Mandatory gender-based analysis and planning at all levels of government, with a priority on the health-care sector is recommended. And finally, a rights-based understanding and discourse of pay equity, and mandatory gender-based analysis and planning to prevent and redress systemic discrimination will provide a strong and sustainable infrastructure for women's pay equity rights to be determined and protected.

We are deeply appreciative for the work undertaken by this Committee. Thank you for considering this submission to the Wage Gap Strategy Review. We look forward to continuing the consultation process.

Sincerely,



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President



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¹²Dr. Pat Armstrong. Source: http://www.genderwork.ca/gwd/?page_id=20