HRTO File No. 2013-161419-I

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

FINAL SUBMISSION OF THE ASSOCIATION OF ONTARIO MIDWIVES

PART A – EVIDENCE

See separate document PART B - For Legal and Remedial Relief Submissions

April 27, 2017

CAVALLUZZO SHILTON McINTYRE CORNISH LLP
Barristers & Solicitors
474 Bathurst Street, Suite 300
Toronto, ON M5T 2S6
Mary Cornish
Jennifer Quito
Lisa Leinveer
Shaun O'Brien
Adrienne Telford

Tel: 416-964-1115
Fax: 416-964-5895

Lawyers for the Applicant

Table of Contents

LIST OF APPENDICES

INTRODUCTION

1. This submission is presented by the Association of Ontario Midwives (AOM) on behalf of over 800 complainant midwives who allege that their *Human Rights Code* right to compensation free of sex discrimination – that is "pay equity" or substantive compensation equality has been violated repeatedly and systematically through actions and inactions, policies and practices over the last more than 20 years by the Ministry of Health and Long Term Care (MOHLTC).

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 and contributions – that is, the midwives' compensation was and is discounted as a result of their gender – an unlawful gender penalty. Further, 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. The right to be free from sex-based discrimination in compensation and to secure substantive pay equality is a fundamental human right guaranteed by the *Human Rights Code*.

PART 1: THE APPLICATION

4. This application has been brought to end the gender based compensation and funding discrimination experienced by midwives as a result of MOHLTC actions and to ensure it never reoccurs.

A. Systemic Gender Discrimination in Compensation and Funding Practices

5. The AOM Application dated November 27, 2013 alleges that the MOHLTC compensation and funding mechanisms have since 1994 permitted, perpetuated and condoned systemic sex-based compensation for the complainant midwives and claims compensation and other and remedial and funding relief with respect to that discrimination as of January 1, 1997. The MOHLTC "contracts" which deliver that sex-based compensation and funding 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 and funding for their work and services contrary to sections 3, 5, 9, 11 and 12 of the *Human Rights Code.*

6. 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.

7. The systemic gender discrimination in compensation which the AOM alleges is deeply rooted in an accumulation of societal, historical and ongoing prejudices which have disadvantaged both midwifery work and women's work specifically and advantaged male predominant physician work. MOHLTC institutional policies and practices have operated to devalue 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 and funding levels; and places limits on the compensation that they can earn and funding they receive and the process by which their pay is determined.

8. Note: With respect to the *Pay Equity Act, b*oth 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.

9. 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.

10. At the time midwifery was regulated, the Ministry relied on a 1993 report by Robert Morton and Associates, "the Morton report" to set the compensation for midwives.[1] This report reflected the consensus of the joint AOM/Ministry Midwifery Funding Work Group which included AOM witnesses President Jane Kilthei and AOM's Vice President Eileen Hutton. This report which analyzed the skill, effort, responsibility and working conditions (SERW) of midwives, CHC Physicians and CHC Senior Nurse/Nurse Practitioner relied on the relative positioning of the compensation of midwives between HC physician and senior primary care nurse/nurse practitioner.

11. Despite provision in the Program Framework for cost of living adjustments the Ministry 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. Thereafter it 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 expert report of Paul Durber filed in this proceeding, including the increasing scope of practice and the administrative and

1 "Summary Report by Robert Morton for the Midwifery Funding Work Group titled 'Compensation for Midwives in Ontario', (July 26, 1993)", Affidavit of Jane Kilthei (Exhibit 1, Tab 15) and "Ontario Midwifery Program Framework Developed by the Midwifery Funding Working Group, September, 1993, September 1, 1993", Affidavit of Jane Kilthei (Exhibit 1, Tab 12).

practice demands placed on midwives by the Ministry's policies, practices and contractual terms.

12. Substantial pay increases have been provided by the MOHLTC to the midwives' equity comparator, the CHC physician, which were not proportionally provided to the midwives in a way which reflected the value of the work.

13. The Ministry has set the compensation of the CHC physicians through negotiations with the OMA since 2004. 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 Nurse II."[2] These salary ranges were detailed in the Ministry's 1991 CHC Compensation Review. These salary ranges are set out in the Morton report.

B. Expert Reports of Inequitable Compensation and Pay Equity Gaps

14. Reports and testimony from pay equity/human rights and economist experts Paul Durber and Hugh Mackenzie have identified conclusions and estimates about the extent of above-noted compensation gaps. Mr. Durber carried out a comprehensive and gender inclusive systemic pay equity comparison of the work (SERW) and pay of Ontario's registered midwives since 1994 relative to the CHC family physician and the CHC nurse practitioner. In making this analysis, Mr. Durber used the equity measuring mechanism applied by the AOM and the MOHLTC at the time of regulation which was to find equitable relative positioning in the health care compensation hierarchy of the midwife, the CHC physician and CHC Nurse Practitioner.

15. On the basis of his human rights analysis of the work in 2013, Durber found that sex bias was operating in the setting of the midwives' compensation/funding by the Ministry. As a result of changes in the SERW of midwifery work since the 1993 Morton – Joint Working Group entry-level analysis, Durber identified compensation adjustments required for Ontario midwives over the period from 1997 to present, to address the pay equity gaps.

16. Taking into account Durber's analysis, Hugh 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.

---

2 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/) :

17. Mackenzie analyzed the actual monetary pay equity compensation payments required as a result of the above-noted Durber analysis.

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

18. The above-noted inequitable compensation violates midwives' human right to equal treatment in employment 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 negotiation planning using gender-based inclusive analysis to plan for and establish levels of compensation funding in the health system that are free from sex-based discrimination.

19. 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.

20. 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.

21. As specifically recognized by human rights jurisprudence, the *Pay Equity Act*, academic research and for indeed Ontario Government statements and reports, 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. 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. Physicians' work is strongly associated with men and they have a long history of privilege and advantages in the health system which is reflected in their compensation.

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 held by the Supreme Court of Canada and the Pay Equity Hearings Tribunal, fair and non-discriminatory pay is necessary not only to meet the necessities of life but also guarantee a sense of dignity and recognition for the value of the important work women perform.[3]

22. As a result of a joint process with the aid of facilitator Elaine Todres, the parties reached a tentative settlement of three agreements – 1) The MPG-TPA Agreement, the AOM-MOHLTC agreement and Memorandum of Agreement. These agreements were ratified by the AOM members in early April, 2017 and ratification by the Ontario Government is expected next week. These agreements were reached explicitly without prejudice to the impacts on those agreements of any rulings made by the Tribunal in this matter. If the Government ratification is confirmed next week, the parties will provide the Tribunal with a copy of the three agreements and will make submission to the Tribunal about the impact of those agreements on this proceeding and any appropriate remedial relief. These agreements, however, do not provide relief for the pay equity gap but rather enable ongoing delivery of services.

PART 2: THE PARTIES

A. The Complainant Midwives and The Gendered Trifecta

1. The Complainants and Ontario's Midwives

23. The complainants range from recent new registrants to the "grandmothers" of midwifery who helped advocate for, design and implement the regulated and MOHLTC funded Ontario Midwifery Program (OMP) which commenced on January 1, 1994. Lists of these 813 complainants, broken down by registration date and by practice groups and their location as urban or rural and remote across the Province are set out in Appendix 1 to this Submission. The complainants represent most of the current and retired practising midwives in Ontario.

24. From 68 registered midwives at start of regulation in 1994, there were nearly 700 registered midwives in 2013, of which approximately 659 were practising at that

3 See *ONA v. Haldimand Norfolk* (1991), 2 PER 105 and *Newfoundland (Attorney General) v. N.A.P.E.,* [1988] 2 SCR 204.

time.[4] There are currently 818 midwives providing care in more than 90 communities across the province. The complainants as well as the rest of Ontario's midwives work or have worked in practices across the province providing MOHLTC managed midwifery health care services for Ontario women and for transgender people.

25. Each year, the number of practicing midwives increases as new registrants start to practice. As well, as demand for midwifery continues to grow at a significant rate.

26. As the Ontario Midwifery Program has still not, after 20 years, reached its target size, each year, the number of practicing midwives increases as new registrants are educated and start their New Registrant Mentoring year. Since the application was filed, most of these New Registrants have joined this proceeding as complainants.

27. Registered midwives are autonomous primary health-care providers who are specialists in providing comprehensive around-the-clock, on-call, perinatal care for women and transgender people 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 newborn infants up to 6 weeks. The knowledge and skills of midwives overlap a number of professional scopes of practice, including family physicians, obstetricians, pediatricians, nurse practitioners, registered nurses and registered practical nurses, social workers and counsellors.

28. This case focuses on the impact of gender discrimination on midwifery compensation and funding. However, not all midwives or midwifery clients are women. There is one male midwife in Ontario. Some midwives and clients are transgender or express gender identity and gender expression in diverse or non-binary ways. Trans people experience societal and systemic marginalization, including in health care and in the labour market.

2. Midwifery Services

29. Midwifery promotes normal childbirth and the prevention of health problems. On January 1, 1994, midwifery became part of the Ontario regulated and funded

---

4 "List of Midwifery Practice Groups in Ontario and Number of Midwives – prepared by AOM (September 2013)", Expert Report of Paul Durber (Exhibit 194, Tab 1) at FN 109.

5 Note: Some Aboriginal Midwives because of their unique status are exempt from the above-noted licensing requirements and were not originally covered by the compensation agreements with the MOHLTC. compensation structures at issue in this application.

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.

healthcare system and is provided free of charge to residents of the province. Midwives provide care in the hospital, birth centre and home setting.[7] 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.

30. Since 1994, more than 224,680 babies have been born under midwifery care, including more than 48.700 births at home.[8]

31. Since regulation, the demand for midwifery has continued to grow at a high rate. MOHLTC data shows that 35% of pregnant Ontarians who seek midwifery services are unaccommodated.[9] 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.[10]

3. The Connection to Women – The Gendered Trifecta

32. Midwives work in a unique "gendered trifecta" context.

    (a) Midwives are the most exclusively female-dominated and sex segregated health care profession in Ontario.[11] Since 2013, there has been one male midwife. There was also one male midwife between 1994 and 1997.

    (b) Midwife means "with woman" and midwifery care is legally mandated to respond to and care for women. 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 empowerment and needs of a woman, and her family, at the centre, including ensuring the woman in labour knows the

---

7 "Ministry of Health and Long-Term Care, 'Midwifery in Ontario: What is a Midwife?", Affidavit of Jane Kilthei (Exhibit 1, Tab 2); "Ontario Hospital Association, College of Midwives of Ontario & Association of Midwives, "Resource Manual for Sustaining Quality Midwifery Services in Hospitals", September, 2010", Affidavit of Jane Kilthei (Exhibit 1, Tab 2).

8 Ontario Midwifery Program, Midwifery Outcomes Report and BORN.

9 Unaccommodated client data were collected by the MOHLTC in its Midwifery Outcomes Reports ("MOR") which is now BORN. See "OMP Minister's Office Foundation Briefing - MOHLTC Slide Deck for Minister Deb Matthews on Midwifery Services, Negotiations, Compensation and Birthing Centres", Government Documents – Melissa Farrell, (Exhibit 182, Tab 112) at p. 2.

10 In every year since 1994 there has been and continues to be an extreme shortage of midwives relative to high consumer demand.

11 "Health Professions Database 2010 Stat Book, Table 2 – Regulated Health Professionals by Sex – 2010", Government Documents – Fredrika Scarth, (Exhibit 184, Tab 2) at p. 10.

midwife attending her birth.[12] Of course, midwives also extend this philosophy to transgender people in their care.

(c) Midwives provide specialized health care which is unique to the reproductive experience of women (and transgender persons). Midwifery has been and continues to be a key part of the MOHLTC's mandate to address women's unique health care needs.[13]

(d) 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.[14]

33. The Ontario Cabinet in deciding to regulate midwifery and 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).[15]

B. The Association of Ontario Midwives (AOM)

12 CMO Practice Standard, Midwifery Model of Care, (Exhibit 239) at p. 2-3.

13 See "MOHLTC Report "Echo: Improving Women's Health in Ontario - Sharing the Legacy - Supporting Future Action 2009-2012", Affidavit of Jane Kilthei (Exhibit 1, Tab 8).

14 Vicki Van Wagner, With Women: Community Midwifery in Ontario, M.A. Thesis, 1991, Affidavit of Jane Kilthei (Exhibit 1, Tab 16).

15 "Cabinet Submission by the Ministry of Health and the Ministry of Colleges and University on Midwifery Education in Ontario with Appendices, June 6, 1991", Joint Book of Official Cabinet Documents (Exhibit 141, Tab 3).

34. The Association of Ontario Midwives (“AOM") is the recognized representative of Ontario’s registered midwives and has existed since 1984. It formed as a result of a merger of the Ontario Association of Midwives and the Nurse Midwives Association in 1982 to create the Association of Ontario Midwives.

35. All registered midwives in Ontario are members of the AOM. The AOM advocates for the professional and employment interests of midwives. This includes providing ongoing professional development, resources and clinical practice guidelines, public education, and promoting accessibility of midwifery care.

36. 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 and the expenses of delivering the OMP's midwifery services.

37. Since midwives (like fee-for- service doctors) are not "employees", the AOM, similar to the Ontario Medical Association, is not a certified bargaining agent under the *Labour Relations Act*.

38. Midwives are designated as independent contractors by the MOHLTC to protect their model of care. Midwives are on-call 24/7 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. The needs of clients 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.

39. The AOM is recognized generally by the Ontario Government as a leading partner in the development of the regulated and funding midwifery system in Ontario.[16] Key initial pre-regulation leaders of the AOM testified in this proceeding, namely Jane Kilthei, Vicki Van Wagner, Elana Johnson, Bobbi Soderstrom, Carol Cameron and Bridget Lynch.

40. The Ontario government relied extensively on the expertise and experience of existing midwives to assist in the creation of its Ontario Midwifery Program. In particular, such midwives, and their organization, the AOM:

    (a) worked with and made submissions to the Task Force on the Implementation of Midwifery in Ontario (TFIMO) chaired by Mary Eberts;

    (b) helped to create the curriculum for the Midwifery Education Program and for the one time Michener Institute of Applied Health Sciences Pre-Registration Programme for grandmothering pre-regulation midwives

16 Affidavit of Jane Kilthei, (Exhibit 1).

(c) served as liaison members of Committees of the Interim Regulatory Council on Midwifery (IRCM) and the subsequent College of Midwives of Ontario;

(d) helped to develop the model of practice, practice standards and guidelines and entry level competencies;

(e) acted as faculty at the three University sites (who had to be practising midwives);

(f) assisted members to set up the practice groups across the province which would deliver accessible midwifery services to Ontario;

(g) helped to set up the Lebel Midwifery Care Organization (LMCO) and worked with the LMCO and later the subsequent trustee the Lawrence Heights Community Health Centre to devolve the program to local TPAs.[17]

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

41. The MOHLTC sets the compensation and funding of midwifery services and manages the Ontario Midwifery Program (OMP).[18] 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.

42. 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.[19]

---

17 See Affidavit of Jane Kilthei, (Exhibit 1) at paras. 320-324; "Funding Agreement between Lebel Midwifery Care Organization of Ontario and Midwifery Practice Group, (January 1, 1994)", Affidavit of Jane Kilthei (Exhibit 1, Tab 133); " Letter from Lawrence Heights Community Health Centre (LHCHC) Interim Trustee to Midwives Collective of Toronto setting out new funding structure and process "to streamline the budget process and position the program for the transition to independent contractor status." (1998-11-18)", Affidavit of Bridget Lynch (Exhibit 61, Tab 55).

18 See MOHLTC pleadings: Form 2 – Response to Application, filed February 14, 2014; Appendix to Form 2 – Response of the Respondent; Response to AOM Request for Missing Information from MOHLTC Form 2, December 5, 2014; Response to AOM Request for Particulars Re: AOM Application, Schedule A, December 5, 2014; Response to AOM Request for Particulars Re: Paragraphs of MOHLTC Appendix to Form 2, December 5, 2014

19 "Results-based Plan Briefing Book 2008-09 (Toronto: Ministry of Health and Long Term Care, 2008)", Affidavit of Nancy Naylor (Exhibit 146, Tab U).

43. The MOHLTC has pursued primary health care reform since the 1970's. Such reform aims to achieve an integrated patient- and client-centred system that supports healthier Ontarians, faster access and the right care and provider at the right time and place.[20] The regulation and funding of midwifery services and the Community Health Centres which started around 1979 are major building blocks of that reform pro**c**ess.

44. 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 and funding system. The MOHLTC acknowledges that it sets the compensation and funding of the operational expenses of midwives.

45. The Ministry is also responsible for the setting of compensation of the CHC salaried physicians and nurse practitioners who were used in 1993 as the key comparators for determining the relative compensation positioning of the new funded midwifery profession as of regulation starting in January, 1994.

46. The Ministry, through contractual directives and policies, including the Transfer Payment Agency ("TPA") template agreement, sets the compensation funding of Ontario's registered midwives.[21] 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.

47. MOHLTC is responsible for key operations in health and long-term care in Ontario through its stewardship role. The Ministry has become less involved in the direct delivery of health care, and more involved in planning and establishing levels of funding and funding models for health care. The Ministry is responsible for establishing overarching strategic directions and priorities for Ontario's health system; developing legislation, regulations, standards, policies, and directives to support those strategic directions; monitoring and reporting on the performance of the health system and on the health of Ontarians; and ensuring that ministry and system strategic directions and expectations are fulfilled.

48. Various articulated goals of the MOHLTC impact on the regulation and compensation of midwifery:

---

20 "MOHLTC, Ontario 's Action Plan for Health Care (Toronto: Ministry of Health and Long Term Care, 2012)", Affidavit of Nancy Naylor (Exhibit 146, Tab C).

21 See, for example, " LMCO template letter to Midwife attaching blank copy of the LMCO and MPG Template Funding Agreement AOM (1994-04-21)", Affidavit of Carol Cameron (Exhibit 44, Tab 9); "MPG - TPA Template Funding Agreement (June 1, 1999)", Affidavit of Bridget Lynch, (Exhibit 61, Tab 81); TPA-MPG Template, 2009, (Exhibit 84).

(a) Primary health care reform;

(b) Providing more gender sensitive and effective health care services for women;

(c) Providing appropriate and safe maternal care for Ontario women and new born care;

(d) Ensuring the equitable integration of the previously excluded midwifery profession into the funded and insured health care system; and

(e) Managing costs while striving for better outcomes. [22]

PART 3: ISSUES TO BE DECIDED

49. The Tribunal's Interim Decision dated September 17, 2014 has already found that the complainant midwives are a protected group under the *Code* and their Application alleges a timely claim of systemic gender discrimination in compensation.

50. Accordingly the issues remaining to be adjudicated by this Tribunal are the following:

(a) Given the allegations of systemic discrimination, have the complainants been adversely treated or suffered disproportionately adverse impacts as a result of MOHLTC systems, policies, practices, procedures, patterns, actions or inactions in relation to their compensation and funding;

(b) Is there a "connection" between any such adverse treatment or impact(s) and the protected characteristic of the sex of the midwives;

(c) If so and therefore a prima facie case of discrimination has been established, has the MOHLTC discharged its evidentiary onus of showing that it conduct, actions and inactions were unrelated in any way to the sex of the midwives; and

(d) If the MOHLTC has failed to discharge that onus, what is the appropriate remedial relief which the Tribunal should order to rectify the discrimination and ensure it does not reoccur.

---

22 Patients First: Action Plan for Health Care (Toronto: Ministry of Health and Long Term Care, 2015), Affidavit of Nancy Naylor (Exhibit 146, Tab B).

PART 4: SUMMARY OF SUBMISSION

51. A complete and comprehensive consideration of the evidence in this matter supports the conclusion that:

    (a) the MOHTLC has violated the rights of the complainant midwives to achieve and maintain substantive equality in compensation and funding and to be free from sex-based discrimination;

    (b) the AOM and midwives are entitled to substantial remedial relief to compensate them and provide restitution for their losses and damages, including their injury to dignity damages; and

    (c) directions are necessary to the MOHLTC to ensure compliance with the *Code* and to prevent the problem from reoccurring.

52. The Ministry, aware of the historical systemic disadvantage and unequal treatment of the almost exclusively female profession of midwifery:

    (a) set the compensation/funding of midwives subsequent to January 1, 1994 in a way which provided unequal compensation and funding to midwives in an environment in which they were subjected to ongoing adverse and unequal treatment, impacts, barriers, prejudice and stereotyping.

    (b) failed to take the necessary proactive, preventative and systemic human rights compliance steps post-1994 to ensure that midwifery compensation and funding was free of sex-based discrimination and pay inequities; and

    (c) failed to ensure such compensation and funding, which it set on an ongoing annual basis, was not influenced by ongoing sex and gender-based stereotypes, prejudice and systemic policies and practices that disadvantaged midwives and favoured the male-predominant profession of physicians and other male work.

    (d) While ignoring the compensation needs of midwives, implemented MOHLTC and other government policies, practices and requirements and established procedures that created, perpetuated and condoned unequal and gendered compensation and funding practices which further reinforced and improperly justified the unequal position of midwives and the lower worth in the health care system;

53. As a result, the MOHLTC violated the twin *Code* goals of "achieving substantive equality and eliminating discrimination" in the words of the Tribunal's Interim Decision reviewed further below in Part .[23] The results of the cumulative

23 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1).

interaction of MOHLTC policies and practices, actions and inactions is that midwives suffered from a gender penalty.

54. 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. MOHLTC, 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 very roughly gender equitable as of 1993. Although a "pay equity exercise" 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.[24]

55. Yet the evidence heard by the Tribunal discloses that equality promoting 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-inclusive analysis in government midwifery decision-making and budgeting and fiscal policies and this included the lack of a human rights pay equity monitoring process. The AOM's expert reports refer to the key importance of such gender based analysis. This analysis is missing from not only from the decision-making affecting midwifery compensation over the years since 1994 but also from the MOHLTC expert reports.

56. 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 physicians in the health care system, the historical suppression of midwifery and recommended a midwifery model of care which would empower women and lead to a less medicalized birth experience for women. The Task Force also highlighted the relative positioning of the midwife between the nurse and the physician.

57. AOM expert evidence also highlights the gendered way that physician dominance is embedded in the health care system, which is particularly problematic for midwives trying to reassert their predominantly female profession.

PART 5: OVERVIEW OF SUBMISSION ORGANIZATION

A. Introduction

24 "Voting Package for AOM Members re Ontario Midwifery Program Framework - with attachments, (October 23, 1993)", Affidavit of Jane Kilthei (Exhibit 1, Tab 118) at p. 3.

58. This submission provides a detailed understanding of the AOM application, the MOHLTC response, the historical and contextual 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; the legal framework within which the evidence concerning the issues of liability and remedial relief should be considered and applied and sets out the remedial relief requested.

B. Focus on Making Visible and Valuing Midwifery Work on Equitable Basis with Physician Work

59. In light of the complexity of the issues and the extensive history required to address appropriately the systemic issues in this case, this main submission summarizes key evidence and more detailed reviews of the evidence are contained in the Appendices listed above in the Table of Contents. The appendices are described below.

60. Appendix 1- “Lists of Complainant Midwives by Registration Date, Practice Group and Urban and Rural and Remote Locations “. Appendix 1 is a complete up-to-date list of all Complainant midwives categorized by registration date, Practice Group and Location.

61. Appendix 2- “Location of All Witness Transcript Evidence by Hearing Date Noting Chief, Cross Examination and Re-Examination Page References”. For ease of reference attached in Appendix 2 is the location of the witness transcript evidence by hearing date.

62. Appendix 3- “List of All Affidavits and Expert Reports”. Appendix 3 contains a list of the witness affidavits and expert reports. At Appendix 6 the facts pleaded by the AOM that have been agreed upon by the MOHLTC have been complied.

63. Appendix 4- “Acronyms of Terminology Used in Proceeding”. Appendix 4 provides a list of Acronyms that were used in this proceeding.

64. Appendix 5- “Overview Summary of Evidence by Chronological Eras since 1994”. Appendix 5 provides a chronological summary of evidence by eras from 1994-2013, theses eras generally mirror the eras used in Durber’s report. It provides a chronological summary of various key evidence by era supporting the claims of sex-based unequal treatment by the MOHLTC for those periods and the resulting remedial relief.

65. Appendix 6-“AOM Pleaded Facts Which Have Been Specifically Agreed To In MOHLTC Pleadings Or Are Agreed as Substantially Accurate or Accurately Stating Contents of Documents”. Appendix 6 is a compilation and list of facts pleaded by the AOM that have been agreed to (as substantially accurate or accurately stating contents documents) by the MOHLTC (in the pleadings).

66. Appendix 7- “History of Midwifery - Suppression and Re-Emergence of Female Predominant Profession”. Appendix 7 sets out the History of Midwifery till 1992.

67. Appendix 8- “The Life and Work of a Midwife – A Demanding and Skillful Job.” A consolidation of evidence of AOM midwife witness regarding their life and work as a midwife has been provided at Appendix 8

68. Appendix 9- “Table of Contents from all AOM Expert Reports”. Provides all of the table of contents from the reports of the AOM experts.

69. Appendix 10- “AOM And MOHLTC Expert Report Text Comparison Charts by Topic Areas”. Appendix 10 is a compilation and comparison chart of all of the Expert Report text (the AOM and MOHLTC experts) divided by topic areas.

70. Appendix 11- “Affidavit Paragraphs of AOM Non-Expert Witnesses Which Directly Respond to MOHLTC Expert Evidence lists”. Appendix 11 cites all of the affidavit paragraphs of AOM non-expert witness which directly responded to the MOHLTC expert reports.

71. Appendix 12- “Detailed Review of Midwifery Compensation and Funding - Reality v. MOHLTC Misstatements”. Appendix 12 responds the MOHLTC assertion that a top level midwife earns $192,265 and provides the breakdown and facts related to a midwife’s compensation.

72. Appendix 13- “Selected Excerpts from Various Government Produced Decision Making Documents including Cabinet Documents”. At Appendix 13 is a consolidation of selected excerpts from various government documents that have been produced, this includes Cabinet documents.

73. Appendix 14 – “How Durber Took Into Account Key Work Aspects Of CHC Physicians As Described By CHC Physician Witnesses And Drs. Price And Graves”. At Appendix 14 how Durber took into account key work aspects of the CHC physician (as described by the CHC physician witnesses and Dr’s Graves and Price) is explained.

74. Appendix 15 – “MOHLTC Created Any Shortage of CHC Physicians”. Appendix 15 explains that the shortage of CHC physicians (that the MOHLTC claims to be a reason for their different treatment from midwives) was created by the MOHLTC.

75. Appendix 16 – “Use of Bargaining Strength As Justification for Significantly Lower Pay Reflective of Gender Bias”. Appendix 16 explains why a bargaining strength is a gendered argument.

76. Appendix 17-“ The Erroneous "Substitution" Arguments Made by MOHLTC Experts”. The MOHLTC arguments regarding erroneous substitution are addressed in Appendix

77. Appendix 18-“ Part Time Status is Gender Equity Issue “. Appendix 18 explains why part-time work status is a gender equity issue.

78. Appendix 19- “Liability Insurance as Expense Not Compensation”. Appendix 19 explains why liability insurance for midwives is not compensation.

79. Appendix 20- “Occupational Hazards and Demands for Midwives”. The health and safety hazards in the daily work of midwives is explained at Appendix 20.

C. Hyperlinking

80. This submission is hyperlinked to assist the consideration of these submissions. For ease of reference, Appendices 2 and 3 provide a hyperlinked list of the transcripts, affidavits and expert reports.

PART 6: INTERIM DECISION AND ITS IMPLICATIONS

A. Introduction

81. The Tribunal's Interim Decision in this proceeding dated September 17, 2014 provides importance directions for assessing the evidence in support of the AOM’s Application and the MOHLTC Response and evidence heard.[25]

82. As a result of a motion by the MOHLTC to dismiss AOM allegations prior to one year before the November, 2013 application, Executive Chair Michael Gottheil issued a decision which made findings binding on the parties in this matter as set out in this Part below:

B. Timeliness of Application

83. The AOM Application covering extensive allegations over a nearly 20 year period is timely as a claim of systemic gender discrimination in compensation.[26] The Tribunal concluded that the 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 connection, alleged patterns of conduct, common circumstances and underlying them than the present Application." [27]

C. Comprehensive and Purposive Approach Required

---

25 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1).

26 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1).

27 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 41.

84. 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".[28] 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.[29]

85. A purposive approach to *Code* compliance aims to ensure 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.*[30]

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

86. The Interim Decision also provided the following guidance about how the AOM's claim of systemic gender discrimination in compensation under the *Human Rights Code* should be considered:

> *[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 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,*

---

28 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 33.

29 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 33.

30 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) para. 35.

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 polices, practices and systems over time, often a long period of lime. 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.*

E. Considerations from Interim Decision for Assessing Evidence

87. 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 determination 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"[31]

(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".[32]

(d) Examine the evidence comprehensively and in aggregate to see the patterns of "action and inaction".[33]

(e) Assess whether there is a Ministry “application over time of wage policies and practices that have tended either to ignore or undervalue work

---

31 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 32.

32 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 31.

33 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 32.

typically performed by women" and the "impact of policies, practices and systems over time, often a long period of time."[34]

(f) Examine the "results" of Ministry's compensation setting systems for midwives and CHC physicians and other professions.[35]

(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."[36]

(h) Examine the "interrelationships between actions (or inaction), attitudes and established organizational structures."[37]

(i) Examine whether the respondent has sought to "prevent all discriminatory practices," based on sex which contribute to systemic gender discrimination in compensation.[38]

88. The AOM submits that the evidence viewed comprehensively and purposively addresses the above issues and supports the conclusion on the balance of probabilities that a systemic set of actions and inactions linked to the sex of midwives and association of CHC physician compensation with male predominance contributed to sex based pay inequities for midwives since 1997.

PART 7: SYSTEMIC GENDER DISCRIMINATION IN COMPENSATION AND ITS INDICATORS AND REMEDIES

A. What is it and What Factors Contribute to It Across the Economic Spectrum

89. The Tribunal in its Interim Decision has already identified as noted above some initial considerations with respect to understanding Systemic Gender Discrimination in Compensation (SGDC) and its indicators and remedies.

90. Dr. Armstrong's reports in this matter along with Dr. Bourgeault's and Mr. Durber's were prepared with the purpose of providing assistance to the Tribunal in this area.

91. Dr. Armstrong testified:

---

34 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 31.

35 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 30

36 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 30.

37 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 33.

38 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 35.

we have lots of evidence that the labour force is segregated into male, predominantly male and predominantly female jobs, not exclusively but that's the overall pattern, and as I said earlier, there's been both change and lack of change. We've seen the continuation of segregation, but within some occupations, and especially in some professions where entry has been based on the success in eliminating gender bias in admission criteria to formal certification, that we have seen more women moving into those kinds of professions and some de-segregation happening.

But, overall, we have a segregated labour force still and, overall, we have lower wages in those jobs done predominantly by women compared to those jobs done predominantly by men." [39]

"*Globally and locally, the research demonstrating a persistent and pervasive overall wage gap between women and men provided the starting point for legislation on gender discrimination in pay"*[40]

"In spite of attempts to explain away the gender wage gap by looking at the personal characteristics of women, at their hours of work and at the nature of their work, research consistently demonstrates that there is systemic discrimination reflecting the undervaluing of women's work that accompanies the ongoing gender-based segregation of Ontario's labour force. This discrimination affects all types of women's employment.[41]

The legislation on pay equity is based on the recognition of occupational segregation that has been accompanied by an undervaluing of the work done primarily by women. Referencing me, the Canadian Human Rights Tribunal in the 2005 Canada Post decision explained that "systemic discrimination refers to discrimination that arises from a variety of factors, not a single factor.

In other words, it begins by understanding that there is systemic, sex/gender-based discrimination in compensation and that such discrimination must be addressed. It recognizes that what is not made visible cannot be valued.…overall patterns of segregation remain and so do the historical legacies linking them to women and men, to lower value and to lower pay for women. [42]

In other words, systemic gender discrimination in compensation arises from gendered systems of disadvantage for women's work and advantage often for men's work which is deeply rooted in historic and ongoing **compensation systems and values.**

---

39 Testimony of Pat Armstrong, Transcript, March 20, 2017 at pp. 36-37.

40 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B), at para 56.

41 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B), at para 6.

42 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B), at para 60.

B. The Equality Role of the State, Politics and Public Administrators Positive and Negative Impacts and Need for Government Support

92. The history of the regulation of midwifery in Ontario clearly shows that an important requirement for promoting gender equality for midwives and identifying and remedying discriminatory barriers is an active and equality promoting state machinery, both legislative, executive and bureaucracy and the absence of one impairs their efforts to achieve gender equality.

93. Both Dr. Bourgeault and AOM midwives testified about the important role that the feminist Ministers, the Women's Health Bureau and Ministry staff played in paving a way for the re-emergence of midwifery and creating a process to ensure the equitable integration of midwives into the health care system.

94. The evidence also shows that pay equity and equality promoting initiatives are vulnerable to governmental changes, especially when there is no specific legislative and policy mechanisms in place to guard against equality eroding initiatives.

C. Understanding Adverse Gender Impacts from Systems, Policies and Practices and their Interactions

95. Compensation, funding, budgeting, economic, and policy mechanisms need to be scrutinized for adverse gender impacts on compensation results.

96. Understanding human rights gender impacts from systems. policies, practices and their interactions, also is assisted by the use of human rights impact assessment tools. The MOHLTC has a Health Equity Impact Assessment Tool which does identify, measure, remedy and monitor equity impacts in health.[43]

D. Enabling Substantive Compensation Equality and Inclusivity through Use of Gender Inclusive Lens and Mechanisms

97. Dr. Armstrong, Dr. Bourgeault and Mr. Durber also testified to the importance of an inclusive gender based analysis (GBA) or lens. Many federal and provincial documents were put in evidence concerning these tools.[44]

---

43 Health Equity Impact Assessment (HEIA) Workbook, (Exhibit 150).

44 See Closing the Gender Wage Gap: A Background Paper, Ministry of Labour (October 2015), (Exhibit 148); Setting the Stage for the Next Century: The Federal Plan for Gender Equity, Status of Women Canada, August 1995, (Exhibit 156); Report of Auditor General of Canada to the House of Commons, Chapter 1 – Gender-Based Analysis (Spring 2009), (Exhibit 157); 2016 Annual Report of the Office of the Auditor General of Ontario, Chapter 3, s. 3.11 - Physician Billing, (Exhibit 186); "Gender Lens: a guide to gender-inclusive policy and program development, British Columbia Ministry of Women's Equality (1997)", Government Documents – Nancy Naylor,

98. Dr. Armstrong testified that gender based analysis was necessary acknowledge and assess how gender matters when it comes to issues of compensation:

> *many people, in addition to me, have shown, the labour force is segregated in terms of jobs predominantly done by women and predominantly done by men, and that's been the case since we have data recorded. So, it makes sense to talk about some jobs as men's jobs and some jobs as women's jobs. Of course, some men do what has been traditionally women's work and some women do what has traditionally been men's work, and some of those have been changing over time but, overall, we see a very persistent segregation.*
>
> *... as the latest report out of Statistics Canada shows that, not only do you see this continuing segregation, as I just talked about it, but the larger the proportion of women, very often you see that the lower the pay of that occupational group. So, there is a long-term association between occupational segregation and the pay that in many cases reflects the undervaluing of the work involved, the demand of the labour involved….*
>
> *the whole basis of equal pay for work of equal value is the notion that you have to begin by assuming that gender matters, and that by beginning with the assumption that gender matters is the only way you can then assess how it matters. And it may not matter negatively but you have to begin with the assumption that gender matters.*
>
> *And we all know from just our daily lives how gender matters. It's the first thing we ask when a baby is born, is it a boy or a girl? And those are differences that have an impact throughout our lives. And we have lots of evidence to indicate that it has an impact in terms of the compensation that goes with jobs predominantly done by women or predominantly done by men.*[45]

(Exhibit 151, Tab 1); "Canadian Experience in Gender Mainstreaming 2001, Status of Women Canada – Gender-Based Analysis Directorate", Government Documents – Nancy Naylor, (Exhibit 151, Tab 3); "Refining a Gender-Based Analysis for Ontario's Primary Care Reform Strategy, Project Report Prepared for ECHO: Improving Women's Health in Ontario (March 31, 2011)", Government Documents – Nancy Naylor, (Exhibit 151, Tab 5); "Departmental Action Plan on Gender-Based Analysis in Response to Audit Findings and Recommendations Contained in Chapter 1, "Gender-Based Analysis" of the Spring 2009 Report of the Auditor General of Canada, Presented by the Privy Council Office, the Treasury Board of Canada Secretariat, and Status Of Women Canada (October 16, 2009)", Government Documents – Melissa Farrell, (Exhibit 182, Tab 118); "Reports of the Auditor General of Canada, Report 1: Implementing Gender-Based Analysis (Fall 2015)", Government Documents – Melissa Farrell, (Exhibit 182, Tab 120); "Ontario Receives Public Input on the Gender Wage Gap Strategy: Province Taking Action to Close the Gap and Help Women Reach Their Full Potential, News Release, Ministry of Labour (April 19, 2016)", Government Documents – Melissa Farrell, (Exhibit 182, Tab 128); "Ontario Working to Close Gender Wage Gap: New Working Group Will Provide Advice Leading to Positive Change, News Release, Ministry of Labour (November 24, 2016)", Government Documents – Melissa Farrell, (Exhibit 182, Tab 131); "Gender Wage Gap, Pay Equity Commission Website (September 18, 2012)", Joint Book of Official Reports (Exhibit 290, Tab 76).

[45] Testimony of Armstrong, Transcript, March 20, 2017, at pp.8-10.

"Q. And so in terms of the issue of gender, you have talked both of that in terms of the occupational power of doctors, and what would you say to the idea that the difference in compensation between midwives and doctors is based on occupation and not related to gender?

A. Well, first of all, I don't think we can say that unless we do a gender-based analysis. So, I think the analysis has to be done to reach anything like that conclusion, and it hasn't been done by the government so far and, in my view, hasn't been done by the expert reports that were -- that I reviewed."[46]

99. Dr. Bourgeault also testified to the important of a sex/gender based analysis.[47]

100. If gender equality promoting mechanisms and planning are not implemented to identify, prevent and redress SGDC means, then systemic discrimination flourishes without being acknowledged or rectified

PART 8: GOVERNMENT, LEGISLATED AND ONTARIO HUMAN RIGHTS COMMISSION RECOGNITION OF IMPORTANCE OF CLOSING ONTARIO'S GENDER PAY GAP AND ELIMINATING GENDER INEQUALITY IN COMPENSATION AND WORK

1. Introduction

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

101. As highlighted below, 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 Background and final Report of the provincially appointed Gender Wage Gap Review Committee were filed as Exhibits in this proceeding.[48] The Government has promised to act to close the gender pay gap.[49]

---

46 Testimony of Armstrong, Transcript, March 20, 2017, at pp. 35-36.

47 See "Expert Report of Dr. Ivy Bourgeault, March 30, 2015," (Exhibit 265, Tab B); "Response Report to August, 2015 Ministry of Health and Long Term Care Expert Reports of Chaykowski, Kervin and Johnson, January 23, 2017," (Exhibit 265, Tab C); Testimony of Ivy Bourgeault, Transcript, March 21, 2017.

48 Closing the Gender Wage Gap: A Background Paper, Ministry of Labour (October 2015), (Exhibit 148); "Final Report and Recommendations of the Gender Wage Gap Strategy Steering Committee, Prepared for Minister of Labour and Minister Responsible for Women's Issues (June 2016)", Government Documents – Nancy Naylor, (Exhibit 151, Tab 29).

49 See "House Statement by the Honourable Kevin Flynn, Minister of Labour and the Honourable Teresa Piruzza, Minister Responsible for Women's Issues on Equal Pay Day, April 8, 2014", Government Documents – Melissa Farrell, (Exhibit 182, Tab 125); "Official Report of Debates

102. And yet at that same time the MOHLTC has been marshalling major resources to fight this application.

B. Green Paper and Ontario's *Pay Equity Act*

103. Ontario's 1985 *Green Paper on Pay Equity*[50] started the Government's commitment to closing Ontario's gender pay gap with its consultation on the development of a pay equity law, which resulted in the 1987 *Pay Equity Act,* effective January 1, 1988.

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

104. Premier Kathleen Wynne in September 2014 issued Mandate Letters to two Ministers which required 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."[51]

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."

(Hansard), Tuesday 19 April 2016", Government Documents – Melissa Farrell, (Exhibit 182, Tab 127); "Ontario Receives Public Input on the Gender Wage Gap Strategy, April 19, 2016", Government Documents – Melissa Farrell, (Exhibit 182, Tab 128); "News Release: Ontario Working to Close Gender Wage Gap, November 24, 2016", Government Documents – Melissa Farrell, (Exhibit 182, Tab 131).

50 Green Paper on Pay Equity, (Exhibit 137).

51 "Mandate Letter from Premier Kathleen Wynne to Minister of Labour Kevin Flynn dated September 25, 2014", Joint Book of Official Reports, (Exhibit 290, Tab 108) at p. 2.

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."[52]

D. Equal Pay Day In Ontario

105. **Minister of Labour's Statement –in Legislature on Equal Pay Day, April, 2015**[53]

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.

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.

---

52 "Mandate Letter from Premier Kathleen Wynne to Minister Responsible for Women's Issues, Tracy MacCharles dated September 25, 2014", Government Documents – Melissa Farrell, (Exhibit 182, Tab 134) at p. 2.

53 House Statement by the Honourable Kevin Flynn Minister of Labour on Equal Pay Day, April 2015: https://www.labour.gov.on.ca/english/news/2015/ms_gwg20150420.php.

E. Government Appointed Gender Wage Gap Steering Committee Background Paper and Report and Government Response:

106. The Government established a Gender Wage Gap (GWG) Steering Committee and consultation process in 2015.

"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".[54]

107. This Committee issued a Background Paper which detailed Ontario's highly sex segregated economy, industries and occupations, including the health care sector and occupations.[55]

108. The GWG Steering Committee's report was released in June 2016.[56] The report referred to implementing a gender lens and to implementing a government-wide gap analysis, but also deferred midwifery issues. The report said, in reference to midwives:

We also heard from two professional groups, midwives…who have specific issues related to the valuation of their work. They raised valuable concepts that have resonated in this report; however, their specific. issues may more properly be addressed through other means.[57]

109. The Government responded on August 25, 2016 by stating that:

The Ontario government has released the final report from the Gender Wage Gap Steering Committee and will immediately start work on a plan to close the gap, create equal opportunities for prosperity and strengthen the economy by eliminating barriers that prevent women's full participation in the workforce.

---

54 Closing the Gender Wage Gap: A Background Paper, Ministry of Labour (October 2015), (Exhibit 148) at p. 33 onwards which addresses the key factors associated with the gender wage gap including discrimination, occupational segregation, caregiving activities and workplace culture and education.

55 Closing the Gender Wage Gap: A Background Paper, Ministry of Labour (October 2015), (Exhibit 148).

56 "Final Report and Recommendations of the Gender Wage Gap Strategy Steering Committee, Prepared for Minister of Labour and Minister Responsible for Women's Issues (June 2016)", Government Documents – Nancy Naylor, (Exhibit 151, Tab 29).

57 "Final Report and Recommendations of the Gender Wage Gap Strategy Steering Committee, Prepared for Minister of Labour and Minister Responsible for Women's Issues (June 2016)", Government Documents – Nancy Naylor, (Exhibit 151, Tab 29) at p. 50.

As a first step toward closing the gender wage gap, Ontario is moving forward with recommendations by:

- *Increasing income transparency in the Ontario Public Service by making salary data publicly available by gender*
- *Requiring gender-based analysis in the government policy process*

…

Many recommendations in the Steering Committee's report also propose further consultation and review to inform the development of a practical, effective cross-government strategy to close the gender wage gap in Ontario.[58]

110. **find Government statement for me to review – referred to gender lens and to government wide pay gap analysis**

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

111. 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"[59]

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

---

58 " Ontario Moving Forward to Close the Gender Wage Gap, News Release, Ministry of Labour, August 25, 2016", Government Documents – Nancy Naylor, (Exhibit 151, Tab 30).

59 "110 days short of equality for working women", Statement from Chief Commissioner of the Ontario Human Rights Commission on Equal Pay Day, April 19, 2016: http://www.ohrc.on.ca/it/node/17611.

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 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 9: MOHLTC DISCRIMINATORY RESPONSE TO APPLICATION – DENY, IGNORE SYSTEMIC CLAIMS AND FOCUS ON CRITIQUING DURBER REPORT RATHER THAN ANALYZING MOHLTC SYSTEMIC ACTIONS

1. Introduction

112. Human Rights claims should be addressed and considered promptly and with human rights informed understanding and constructive and informed dialogue aimed at ensuring *Code* compliance. The MOHLTC's response here is and was just the opposite.

A. Deny all Claims

113. From its initial Response Appendix 2 dated February 14, 2014 to the Application, the MOHLTC has denied all allegations and has spent no time establishing that it had procedures in place to ensure that its compensation and funding setting practices for midwives were and are free of sex bias. Instead, the MOHLTC categorically states that 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 compensation and funding 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 ensure its funding actions are *Code* compliant.[60]

B. Deny Sex/Gender is Considered and Adopt Gender Blind Approach So No Equity Action Need be Taken

114. The MOHLTC unabashedly, as detailed in this submission and appendices, takes the discriminatory position that:

60 Response to AOM Request for Particulars Re: AOM Application, Schedule A, December 5, 2014 at para. 30.

(a) it does take into account in decision-making the fact that midwives are almost exclusively women;

(b) it does not consider “sex” or "gender" when it sets compensation or develops compensation setting funding practices of an almost exclusive female vulnerable profession and for professions like CHC physicians who are associated with men;

(c) it did not and does not use any gender lens in its compensation and funding decision-making;

(d) it did not and does not have any equity mechanisms in place which it applied to midwives when it made decisions about them; and

(e) it did not have any comparison mechanism in place to monitor the SERW of midwives and their comparators and their ongoing pay systems and total compensation.[61]

115. These admissions are part of the foundational evidence which supports the AOM's prima facie 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, midwifery compensation and funding, even if established relatively equitably as of 1994, quickly became inequitable.

116. The Government, to this date, (more than 3 years after the filing of the complaint and nearly four years from when the AOM clearly stated a human rights claim would be filed) has stubbornly held on to its position that it does not have to do anything until a Tribunal orders it to do so and can remain gender blind and unaware of its human rights responsibilities.

117. After over many years of frustrating efforts to get the MOHLTC to consider their human rights claims, the complainants experienced further inequity when the filing of their human rights application only lead the MOHLTC to seek to deny and attack their claims with a complete failure to engage genuinely with the AOM on collaboratively addressing the serious issues raised by its Application. Instead of

---

61 See Form 2 – Response to Application, filed February 14, 2014; Appendix to Form 2 – Response of the Respondent; Response to AOM Request for Missing Information from MOHLTC Form 2, December 5, 2014; Response to AOM Request for Particulars Re: AOM Application, Schedule A, December 5, 2014; Response to AOM Request for Particulars Re: Paragraphs of MOHLTC Appendix to Form 2, December 5, 2014; Testimony of Sue Davey, Transcript, October 20, 2016; Testimony of Sue Davey, Transcript, October 21, 2016; Testimony of Sue Davey, Transcript, November 1, 2016; Testimony of Sue Davey, Transcript, November 2, 2016; Testimony of Nancy Naylor, Transcript, November 3, 2016; Testimony of Laura Pinkney, Transcript, November 4, 2016; Testimony of Laura Pinkney, Transcript, November 8, 2016; Testimony of Laura Pinkney, Transcript, December 2, 2016; Testimony of Melissa Farrell, Transcript, December 2, 2016; Testimony of Melissa Farrell, Transcript, December 7, 2016; Testimony of Melissa Farrell, Transcript, December 8, 2016; Testimony of Fredrika Scarth, Transcript, December 8, 2016; Testimony of Fredrika Scarth, Transcript, December 9, 2016

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.

118. The MOHLTC pleadings, expert evidence (which it adopted)[62] and affidavits ignore the "unique" systemic form of discrimination 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 the *PSAC* cited in the Interim Decision "through an examination of historical patterns (at paras. 117-118)."[63]

119. In fact, the MOHLTC initially responded to the AOM's Application by taking the position that such historical patterns were irrelevant and the only evidence that could be considered was that dating one year back from the application – namely back to November 27, 2012. This position by itself shows a failure to understand systemic gender discrimination in compensation, as the Tribunal pointed out in its Interim Decision.

120. The MOHLTC spent a significant amount of time cross examining AOM witnesses about whether they used the precise term "pay equity" when asked for compensation adjustments as if the complainants only had a human right to pay equity if they asked for it in very precise terms.

121. In order to defend its gender-blind position, the MOHLTC decided that it had to show that it never carried out any such equity analysis at the time of regulation so as to support its position that it had no obligation to continue such an equity process as the AOM alleged and Durber supported.

122. This has left the parties and the Tribunal in the absurd position where much time and evidence has been taken in this proceeding for the MOHLTC to prove that it did not engage in any gender equity or rough pay equity analysis when it first set midwives' compensation. This is despite documentation and evidence which clearly points to such a process which is detailed in Part 27 below.[64]

123. 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, although not the formal process or requirements used under the *Pay Equity Act*. The document, prepared by Mr. Robert Morton which is titled

---

62 Response to AOM Request for Particulars Re: AOM Application, December 5, 2014, which relied in part upon its expert reports as its response for most of its responses to AOM Schedule A to its Application paragraphs.

63 *AOM v. Ontario (Health and Long Term Care)* 2014 HRTO 1370 (CanLii) (J1) at para. 31.

64 See Affidavit of Jane Kilthei, (Exhibit 1); Testimony of Jane Kilthei, Transcript, September 14, 2016; Testimony of Jane Kilthei, Transcript, September 15, 2016; Affidavit of Robert Morton, (Exhibit 176); Witness Statement of Margaret Anne McHugh, (Exhibit 231); Testimony of Margaret Anne McHugh, Transcript, February 21, 2017.

"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 tor 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.

124. Further, the Ministry's own January/February, 1993 "Options Paper" authored by the MOHLTC Midwifery Implementation Coordinator, Margaret Anne McHugh shows that a "pay equity" assessment was part of the considerations.

125. AOM witness Jane Kilthei who lead the AOM team in the Joint Working Group testified 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".[65]

126. Despite this evidence, the Ministry has adopted its expert reports, including that of Dr. Richard Chaykowski which state that the July 1993 Morton report which reflected the consensus of the Joint Work Group process was fundamentally flawed in any event. However, the witness and documentary evidence make 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.

C. Perpetuate Prejudices and Stereotypes and Inaccuracies about Midwifery and Physician Work, Education and Pay

127. As is reflected in the MOHLTC's evidence and pleadings in this proceeding and its adoption of positions taken by its experts' reports, the MOHLTC is contributing to and perpetuating the stereotypes and prejudices about midwifery and physician work. This includes a lack of understating the difficulty and onerous nature and risks of midwifery work and education and its costs and overemphasizing physicians'.

128. All of above contributes to rendering invisible key aspects of midwifery work and while over-describing CHC physician work.

D. Focus on Critiquing the Durber and Mackenzie Reports and Ignoring Context and History

65 "Voting Package for AOM Members re Ontario Midwifery Program Framework - with attachments, (October 23, 1993)", Affidavit of Jane Kilthei (Exhibit 1, Tab 118) at p. 3.

129. Further, the MOHLTC immediately in its response Appendix 2 dated February 14, 2014 repudiated completely the Durber and Mackenzie 2013 reports, when at that point, it did not have the expert reports of Bass, Chaykowski, Kervin and Price. Instead of engaging in a dialogue with the AOM about the issues, the MOHLTC hired experts to criticize 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, and the Hugh Mackenzie report which estimated key damages owing to the complainants.

130. The MOHLTC pleadings did not initially respond to the extensive AOM application. Instead, the Government hired experts to speculate or assume based on general studies for example about the impact of education on compensation in order to justify the substantial difference in compensation between the CHC physician and the midwife – e.g. difference in education, scope of practice, authorized acts and number of clients. Neither the MOHLTC nor its experts have produced any systematic and gender inclusive analysis of the work of the midwife or the work of the CHC Physician and Nurse Practitioner.

131. These experts were not provided with the Government documentation now exhibits in this proceeding which actually showed actual the basis for government compensation decision-making in relation to the midwives and the CHC physicians and other comparators.

E. Setting Up Unnecessary Divisions and Disputes with Physicians

132. The AOM submits that in its defence to allegations about its own conduct, the MOHLTC asked its experts to answer some questions which were based on issues in the AOM application taken out of context. For example, asking CHC physicians whether it is true they "cure" instead of "care". This served to set up factual disputes and interprofessional animosity, which are a diversion from the main issues to be decided.

133. The MOHLTC without foundation takes the position that the midwives are arguing that the female CHC physicians are not being paid for their skills and valuable contributions but rather are trading on historical male privilege. The CHC physicians do not appear to have been given any context about the implications of the historical and current privileges and dominance which physicians have had in the health care system. This approach is a divisive one – ensuring that women are not disadvantaged in pay because of their gender does not mean that the value of any comparator's work is thereby denigrated.[66]

134. The AOM application and experts reports made no denigrations of the work of CHC physicians nor claim that CHC physicians did not "care" when they performed their work, nor that the work of CHC physicians was not highly skilled and important. It appears that the CHC physicians had not been given the AOM

66 Testimony of Pat Armstrong, Transcript, March 20, 2017 at pp. 28-29.

experts reports and did not have full understanding of the context in which they were being asked to provide evidence.

135. While the comparator human rights approach is not used to downgrade the skills of the comparator, it is appropriate in a human rights comparison process to make sure there is an evidence based accurate description and valuation of comparator work. Dr. Armstrong and Mr. Durber also testified to the problem that work identified with men has been overstated. So accuracy is important. In that regard, it was only on cross examination of the CHC witnesses that it became evident that a great deal of the work performed by the CHC physician is also performed by the Nurse Practitioner who is and was paid vastly less money and has significantly lower educational requirements.

F. Ignore the Actual Specifics of How Midwifery and Physician Compensation was Set

136. The MOHLTC, instead of actually addressing why it set the compensation of midwives and CHC physicians as it did, hired MOHLTC experts to provide opinions about possible rationales for the acknowledged substantial difference in compensation. These assumptions, unrelated to the actual facts underlying the MOHLTC compensation setting decision-making, are irrelevant.

G. Denial of Obligation to Negotiate with Midwives

137. As well, the Ministry since this Application was filed 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 unilaterally but after consultation. This is not consistent with government documentation produced by the MOHLTC over nearly 20 years. (See Appendix 13 - Chart of Selected Government Documents) which refers to "negotiations" with the AOM since 1993. This change of heart in the description of its interactions with the AOM appears to be based on its view that the CHC physicians earn substantially more in part because the MOHLTC asserts it must bargain with them.

138. While the Cabinet Submission in September, 1993 speaks positively of the "cooperative negotiations" process which lead to the agreed upon September 1993 OMP Framework and agreement on the compensation level, great efforts are later taken by the MOHLTC to show that they don't have to negotiate with the midwives.

PART 10: EVIDENCE HEARD AND CONSIDERATIONS FOR ASSESSMENT OF NON EXPERT EVIDENCE

A. Introduction

139. The Tribunal heard extensive evidence – affidavits, in person testimony and documentary over a period of 50 hearing days. This started with opening statements on June 1 and 2, 2016, the filing of AOM and MOHLTC witness affidavits over the period from the end of July to early September, 2017 and the hearing testimony with reference to those affidavits and all the AOM and MOHLTC expert evidence starting on September 14, 2016 and concluding on April 4, 2017.

140. The affidavit evidence filed constituted the witnesses' testimony in chief supplemented generally by an hour of oral examination in chief, cross examination and re-examination. The Tribunal heard the non-expert evidence first and then heard the expert evidence next along with reply and surreply evidence. The Tribunal made a decision to hear some evidence in person and some evidence was heard by way of a special examiner process. All evidence was transcribed.

141. For ease of reference, the AOM has attached as Appendix 2 to this submission a document setting out the Location of All Witness Transcript Evidence by Hearing Date. In addition, attached as Appendix 3 is a List of All Affidavits and Expert Reports, hyperlinked.

B. Tribunal Jurisprudence Concerning Assessing Non Expert Evidence

142. When assessing credibility of witnesses the Tribunal often cites and applies the well-established principles stated by the British Columbia Court of Appeal in *Faryna v. Chorny.* The Court held:

> *The credibility of interested witnesses, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carries conviction of the truth.* ***The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions.*** *In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions".*[67] (Emphasis added)

143. The Tribunal in *Koitsis v. Ajax Automobile (2008) Inc.* stated: "a conclusion about the credibility of witnesses develops from various interrelated findings, such as whether, on a balance of probabilities, the evidence was sufficiently probable, logically connected to other points, and/or buttressed by independent evidence".[68] Other factors the Tribunal cited in this case were: findings with

---

[67] *Faryna v. Chorny*, [1952] 2 D.L.R. 354 (BCCA) (J102) at para. 11.

[68] *Koitsis v. Ajax Automobile (2008) Inc.* 2016 HRTO 1628 (J104) at para. 70.

respect to the state of the witness, such as candour or evasiveness, capacity to perceive and remember, and attitude towards the parties. The Tribunal in *Cugliari v. Telefficiency Corporation (2006)* found other factors for assessing credibility: the witness's motives, the witness's relationship to the parties, the internal consistency of their evidence, and inconsistencies and contradiction in relation to other witnesses' evidence.[69]

C. AOM Evidence

144. The Tribunal heard evidence from the following AOM witnesses which included their affidavits, attached documentary exhibits and oral testimony:

(a) Jane Kilthei, Vicki Van Wagner, Bobbi Soderstrom, Carol Cameron, Bridget Lynch, Remi Ejiwunmi, Elana Johnson, Katrina Kilroy, Madeleine Clin, Elizabeth Brandeis, and Kelly Stadelbauer;

(b) Midwives who are representative of the injury to dignity claims of all the complainants namely Maureen Silverman, Daya Lye, Nicole Roach, Rebecca Carson and Jackie Whitehead.

(c) External witnesses: John Ronson, lead consultant for the Courtyard report; Moshe Greengarten, lead consultant for the Hay Group reports, and Theresa Agnew, Executive Director of the Nurse Practitioners Association of Ontario.and long time CHC Nurse Practitioner.

(d) The AOM called in reply, Margaret Anne McHugh, who was the MOHLTC Women's Health Bureau Midwifery Implementation Co-ordinator for the period August, 1993 to June, 1994.

D. MOHLTC Evidence

145. The Tribunal heard response evidence from the following MOHLTC witnesses which included their affidavits, attached documentary exhibits and oral testimony.

(a) Sue Davey, Laura Pinkney, Nancy Naylor, Melissa Farrell, Fredrika Scarth, David Thornley and four Community Health Centre physicians – Nicole Nitti, Tara Kiran, Susan Woolhouse and MaryRose MacDonald.

(b) Three witnesses in surreply after the AOM advised it was calling its former MOHLC employee, Ms. McHugh, as a Reply witness. Those witnesses were: Jodey Porter, Anne Premi and Martha Forestell.

E. Assessment Of Reliability And Relevance Of AOM Non Expert Evidence

69 *Cugliari v. Telefficiency Corporation* 2006 HRTO 7 (J103).

146. Overall, the AOM submits that its non-expert witnesses testified in a clear and credible manner and the evidence overall provides a coherent and comprehensive evidentiary basis to support its pleaded application

147. AOM witnesses testified to matters which they had direct knowledge of which spanned over 30 years and which were backed up often by supportive and contemporaneous documentation.

148. With some exceptions, the MOHLTC witnesses in their affidavits and testimony mostly did not specifically challenge the testimony of AOM witnesses.

F. Assessment Of Reliability And Relevance Of MOHLTC Non Expert Evidence

149. On the other hand, the evidence of the MOHLTC witnesses suffered from a number of problems:

(a) The MOHLTC decided to call single witnesses to cover large periods of time including substantial periods when they had no direct knowledge of events. For example:

(i) Ms. Davey was called as the sole initial government witness for the pre-regulation era when she did not get hired by the MOHLTC until the spring of 1993.

(ii) Ms. Pinkney was called to testify to the period from 2006-2012 when she was at times on extended leaves or was not present at meetings.

(b) As well, the evidence of the MOHLTC witnesses on cross examination was often not responsive to difficult questions which called the witnesses to account for government actions.

PART 11: EVIDENCE AGREED AS ACCURATE OR SUBSTANTIALLY ACCURATE

A. Introduction

150. The AOM and its experts have attempted various times to identify areas of agreement and clarify disputes with the MOHLTC. That met with some limited success.

B. Areas of Agreement

151. The AOM and the MOHLTC have agreed to date on certain facts as follows:

(a) 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; The AOM created an initial document attached to its Reply to the MOHLTC Response to its application which set out the paragraphs in its Application which the MOHLTC specifically stated it agreed to.

(b) as a result of the agreements or statements of substantial accuracy which were included in the MOHLTC December 4, 2014 Response to Particulars Re: AOM Application.

152. Attached as Appendix 6 is a document which sets out those agreements or statements of substantial accuracy - 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

153. Further, the AOM experts set out in their reports the areas of agreement which they had with the MOHLTC experts.[70]

C. Government Documents Which Support the AOM Claim

154. As well, the Government has produced substantial documentation which supports the AOM application.

155. The MOHLTC 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.

156. Attached as Appendix 13 is a Chart – Selected Excerpts from Various Government Produced Decision-Making Documents including Cabinet Documents which sets out many important factual statements which the AOM agrees with. These documents cover the following topics:

(a) Public Demand and Shortage of Midwifery Providers and Birth Centres; Waitlists of Women for Midwifery Services and Relationship to Shortages of Other Primary Care Obstetrical and Newborn Care Providers

(b) Midwifery and the Gendered Trifecta - The Strong Association of Midwifery with Women and Engendering Women's Health Care

---

70 See for example, "Response to MOHLTC Expert Reports (March 31, 2015)," (Exhibit 194, Tab 2), at pp. 9-11;

(c) MOHLTC's Views on Expanding Midwifery Services In light of Demand, Health Care Reform Objectives and Access to Primary Care Obstetrical and Newborn Care Providers

(d) MOHLTC Perceived Risks of Failure to Fund Midwifery Services Expansion

(e) Cost-Effectiveness of Midwifery Services

(f) Important Role of Midwives in Addressing Shortages of Other Obstetrical Care Providers

(g) Ongoing Hospital Integration Barriers Experienced by Midwives

(h) Excellent Health Outcomes of Midwifery and High Client Satisfaction

(i) MOHLTC Recognition of Ontario Medical Association's Views on Midwifery and Its Impact on Physicians and their Work and Pay

(j) Goals & Objectives of the Ontario Midwifery Program

(k) MOHLTC's Position on the AOM as the Representative of Funded Midwives in Negotiations

(l) Liability Insurance Premiums Treated as Operational and System Disbursement/Expense Not Compensation

(m) Program Framework Document and Task Force Report as the Foundation of the OMP

(n) MOHLTC Control of Midwives To Secure Government and OMP Objectives

(o) Government Statements Re: Midwifery Compensation

(p) Demanding Nature of Workload, On Call and Working Conditions Midwives

(q) Alignment of CHC Physician Compensation To Provide Equity with other Primary Health Care Provider Physicians

PART 12: THE PROPER ROLE FOR EXPERT EVIDENCE IN THIS CASE

A. Introduction

157. The parties have put forward extensive expert evidence in this matter. However, the Applicant recognizes that the Tribunal has its own specialized human rights expertise to rely upon and therefore has aimed to provide expert evidence which

can supplement the Tribunal's expertise and provide assistance in areas which the Tribunal has not previously considered.

B. Principles to Apply

158. In assessing the proper role of expert evidence, including whether it is necessary to assist the Tribunal to reach its adjudication conclusion, the Tribunal should consider the following principles:

159. **Necessity Test.** First, with respect to the threshold requirement of "necessity", it is well recognized in Tribunal jurisprudence (see particularly *Nassiah v. Peel Regional Police Services Board*[71], ("*Nassiah*") that in the human rights context "necessity" encompasses a more relaxed standard than the strict "gatekeeper" role found in the criminal or judicial review context. The *Nassiah* Tribunal held that whether expert evidence is "necessary" must be considered using a contextual analysis which "takes into account the nature of human rights hearings and the often subtle nature of discrimination."[72]

160. The *Nassiah* Tribunal cautioned against a too narrow approach to the assessment of expert evidence,[73] citing the approach taken by the Nova Scotia Board of Inquiry in *Johnson v. Halifax (Regional Municipality) Police Service*[74]*, at paras. 92-93:*

> ***Expert evidence in discrimination cases*** *can be statistically based, with an air of scientific validity but* ***often it is highly qualitative and uses the "softer" methodologies of the social sciences. This is clearly appropriate where we are dealing with the elusive but nonetheless powerful concept of human dignity that underlies human rights law. The often subtle nature of discrimination puts a high burden on complainants and I would urge future boards not to be too quick to characterize proffered expert advice as merely "helpful" and thus excluded"****. (Emphasis added)*

161. The *Nassiah* Tribunal also cited (para. 35) the decision in *Radek v. Henderson Development Canada Ltd*[75], where the BC Human Rights Tribunal stated in part:

> *"…* ***evidence may be necessary which serves the function of clarifying or contextualizing the issues in dispute****".(Emphasis added)*

---

71 *Nassiah v. Peel Regional Police Services Board*, 2006 HRTO 18 (J7).

72 *Nassiah v. Peel Regional Police Services Board*, 2006 HRTO 18 (J7) at para. 36**.**

73 *Nassiah v. Peel Regional Police Services Board*, 2006 HRTO 18 (J7) at para. 34.

74 *Johnson v. Halifax (Regional Municipality) Police Service,* 2003 N.S.H.R.B.I.D No. 2 (J8) at paras. 92-93.

75 *Radek v. Henderson Development Canada Ltd*, 2004 BCHRT D No. 364 (J18).

162. With respect to Dr. Armstrong's expert evidence, the AOM notes that her type of sociological expert evidence and opinions have been relied upon and therefore been considered necessary by Courts and specialized pay equity tribunals and general human rights tribunals for over 25 years. Based on her international and domestic experience and understandings, she is an expert in the appropriate mechanisms needed to address the unequal labour market compensation structures women face and therefore realize a right to be free from pay discrimination. Mechanisms for enforcing the right to gender equality and the content and enforcement of human rights and the role of the state are established areas within the field of sociology and within her area of expertise. Notably, the Pay Equity Hearings Tribunal relied on Dr. Armstrong`s evidence in detail to develop the principles in its two groundbreaking cases, *ONA v. Haldimand Norfolk*[76] and *ONA v. Women's College Hospital (No.4).*[77]

163. Second, the novel nature of the issue, including the fact that it has never before been addressed by the Tribunal, as is the case with systemic gender discrimination in compensation, supports the admissibility of expert evidence on the issue. The Tribunal in *Nassiah* recognized that the novelty of the subject matter of an expert's evidence will weigh towards its admission. In allowing the evidence of a racial profiling expert, the *Nassiah* Tribunal emphasized the fact that it was the Tribunal's first time considering a racial profiling complaint relating to a police investigation stated:[78]

> *[37]* ***Regardless of the extent to which racial profiling has been raised in other cases, the Commission asserts that this is the first complaint before the Human Rights Tribunal in Ontario alleging racial profiling in a police investigation. I find that the proposed evidence would provide useful context about the meaning and existence of racial profiling (if any) in police investigations in Canada against which I can better understand the circumstances in which it may occur and the factors indicative of it. In that sense I find the proposed evidence to be relevant and "necessary" using the less strict standard appropriate for a human rights process.*** *(Emphasis added)*

164. The matters which Dr. Armstrong is addressing in her report have never been addressed before by the Human Rights Tribunal of Ontario. Nor have they been addressed specifically by the Ontario Human Rights Commission in its Guidelines. Notably, some of these matters have been addressed by the Pay Equity Hearings Tribunal relying in part on the evidence of Dr. Armstrong. Accordingly, this favours the admissibility of this evidence.

---

76 *ONA v. Haldimand Norfolk* (1991), 2 PER 105 (J2).

77 *ONA v. Women's College Hospital (No.4) (1992) 3 P. E. R. 61* (J3).

78 *Nassiah v. Peel Regional Police Services Board*, 2006 HRTO 18 (J7) at para. 37.

165. Third, the Tribunal has not adopted any general rule that it will not hear evidence that relates to the ultimate issue before the Tribunal. As the Tribunal stated in *OHRC v. Barbara Turnbull et al and Famous Players Inc.*,[79] at para. 38:

> *The Tribunal is cognizant that the role of the expert is not to usurp the function of the trier or to replace it.* ***The Tribunal may accept or reject all or part of an expert's opinion evidence (even where uncontradicted) including that which relates to the ultimate issue before the trier****." (Emphasis added)*

166. The Tribunal in *Turnbull*, citing the *Law of Evidence in Canada*[80]*, J. S*opinka, S. N. Lederman and A. W. Bryant (2nd ed. 1999, Butterworths), at para. 12.70, for the proposition that there was no absolute bar on evidence relating to the ultimate issue.

167. The *Nassiah* Tribunal rejected the respondent's assertion that the expert would be impermissibly opining on the very issue before the Tribunal (para. 39-40):

> *[39] On that point, I find the comments of Justice Lane in the civil case of Peart v. Peel (Regional Municipality) Police Services Board,*[81] *[2003] O.J. No. 2669 on the use of opinion evidence on racial profiling very useful:*
>
> *23 If I find that the underlying `facts' upon which Dr. Agard's opinion is based actually existed on December 1, 1997, then* ***his evidence provides me with a basis for an inference that racial profiling was being practiced that day by one or both officers. That is the classic role of the expert: to provide the court with a ready-made inference based on scientific, medical, psychiatric, engineering or similar learning, which the court can draw if certain identified underlying facts are demonstrated to exist. … But the inference is one that the court draws. Dr. Agard's opinion is not a substitute for the court's own analysis of the evidence, taking account in so doing of the societal background and the description of the indicia of racial profiling which he has provided, to determine what the facts actually were on that day.*** *Nor is the inference a mandatory one; it is available for the court to draw if the court is persuaded on the balance of probabilities that it is the more probable explanation for the events in question…*
>
> *[40] Regardless of Professor Wortley's opinion on whether factors in this case point to racial profiling, that is my decision to make, and I will not be unduly influenced by his opinion on that issue. (Emphasis added)*

---

79 *Turnbull v. Famous Players Inc.,* 2003 HRTO 10 (J9) at para. 38.

80 *Law of Evidence in Canada, J. S*opinka, S. N. Lederman and A. W. Bryant (2nd ed. 1999, Butterworths), at para. 12.70.

81 *Peart v. Peel (Regional Municipality) Police Services Board*, [2003] O.J. No. 2669 (J19).

168. Finally, the AOM submits that its experts do not make impermissible legal argument. Dr. Armstrong's expert opinion that a proactive pay equity analysis which makes visible and values women's work is required to realize the human right of pay equity assists the Tribunal by providing it with her expertise which is rooted in sociology and public policy human rights understandings about promoting gender equality and eliminating gender inequality. It contains normative expert statements regarding systemic gender discrimination in compensation rather than legal conclusions about the interpretation of the *Human Rights Code*, the evidence satisfies the test of necessity in *R. v. Mohan*[82], as adapted by the Tribunal in *Nassiah v. Peel Regional Police Services Board* to the human rights context.

169. Unlike the experts called in *Public Service Alliance of Canada v. Minister of Personnel for the Government of the Northwest Territories*[83], Dr. Armstrong's expertise is not derived primarily from the legal field.

170. Furthermore, unlike a proposed expert in *Omuruyi-Odin v. Toronto District School Board*[84], Dr. Armstrong has neither sought to instruct the Tribunal on what its legal conclusions should be nor been insufficiently respect of the Tribunal as decision-maker.

171. For all the foregoing reasons, it is entirely appropriate for the Tribunal to admit and rely on the expert evidence put forward by the AOM.

PART 13: AOM EXPERT EVIDENCE - RELIABLE, RELEVANT AND ASSISTS TRIBUNAL

A. Introduction

172. The AOM filed a very extensive application with ten volumes of supporting documents and two November, 2013 expert reports with its Application, that of Paul Durber and Hugh Mackenzie. It was hoped that those initial expert reports would assist not only in providing foundational support for the application and assistance to the Tribunal, but also as an evidence based way of encouraging a dialogue with the MOHLTC. That was not to be the case, as noted in Part 9 above.

173. As well, for ease of reference by the Tribunal and MOHLTC counsel, the AOM has created Expert Comparison Charts which took verbatim text from the

---

82 *R. v. Mohan*, [1994] 2 S.C.R. 9 (J20).

83 *Public Service Alliance of Canada v. Minister of Personnel for the Government of the Northwest Territories,* [2001] C.H.R.D. No. 26 (J10) at paras 13-21.

84 *Omuruyi-Odin v. Toronto District School Board*, 2002 OHRBID No. 21 (J11) at para. 55.

MOHLTC and AOM expert reports and put that text under relevant topic headings. There is no analysis in the Charts – just actual text. Attached as Appendix 10 is a list of the topics covered by those Charts and the actual Comparison Charts are being provided on the USB key with this submission. The topics are as follows:

1. Scope of Report; 2. Expertise and Experience 3. Summary of Conclusions;4. Analysis Framework or Methodology; 5. Compensation and Sex/Gender; 6.Overall Labour Market and Employment Issues; 7. Midwifery; 8. Physicians and CHCs; 9.Nursing and Nurse Practitioners; 10. Ontario's Maternity Care System; 11.Employment of Midwives; 12. Compensation of Midwives;13. Other Compensation Measures for Midwives; 14.Individual Characteristics, Labour Supply and Individual Earnings of Midwives; 15.Employment of CHC Physicians; 16.Compensation of CHC Physicians and Physicians;17.Other Compensation Measures for CHC Physicians;18. Individual Characteristics, Labour Supply and Individual Earnings of CHC Physicians; 19..Employment and Nurse Practitioners 20.Compensation and Nurse Practitioners and Nurses.21Criteria for Assessing Sex/Gender Predominance/Association; 22. Application of the criteria sex/gender predominance; 23. Overview of Claim of Sex Based Discrimination and MOHLTC Expert Critique; 24 Choice of Comparator(s) for Midwifery; 25.Methodology for Valuing Work - General; 26. Choice and Application of the New Zealand Equitable Job Evaluation Factor Plan - Working Towards Gender Equality; 27. Collection of Job Content – Midwifery Work; 28. Job Content – CHC Physician Work ;29. Job Content – Nurse Practitioner; 30.Ratings of the Work of the Three Professions 31. Current Rating Results; 32. Ratings Over Time - 1994-2013; 33. Comparing Compensation of Midwives and CHC Physicians;34. Mackenzie Report and Analysis; 35. Assessing Factors Which May Justify the Compensation Differences - Allowable Exemptions for Non-Discriminatory Factors; 36. Other Issues: and 37.References Cited by Experts and List of Appendices Tables and Figures

B. Mr. Paul Durber

1. Reports

174. Mr. Durber prepared three reports: a) Initial Report dated November 24, 2013 (revised March, 2015)[85]; b) Report dated March 30, 2015 responding to the November, 2014 MOHLTC expert reports of Bob Bass, Dr. Richard Chaykowski, Dr. John Kervin and Dr. David Price[86]; and c) Response Report dated January 3, 2017 which responds to the August 2015 reports of MOHLTC experts.[87]

85 "Examining the Issue of Equitable Compensation for Ontario's Midwives (November 24, 2013)," (Exhibit 194, Tab 1); "Response to MOHLTC Expert Reports (March 31, 2015)," (Exhibit 194, Tab 2), Note that for ease of reference, Mr. Durber's initial report was revised to include corrected calculations as set out in his March, 2015 report.

86 "Response to MOHLTC Expert Reports (March 31, 2015)," (Exhibit 194, Tab 2).

87 "Reply Report to August, 2015 MOHLTC Expert Reports of Bass, Chaykowski, Kervin and Graves (January 3, 2017)," (Exhibit 194, Tab 3).

2. Expertise and Experience

175. Mr. Durber is the former Director of the Canadian Human Rights Commission Pay Equity Unit. After his retirement, he became an independent consultant in pay equity and job evaluation providing advice to clients across Canada, including Ontario. His expertise in the areas of job evaluation, pay equity and compensation has been acknowledged in proceedings of the Ontario Pay Equity Hearings Tribunal and the Canadian Human Rights Tribunal.

176. Mr. Durber has over 30 years of experience as reflected in his Curriculum Vitae and summarized in his November 2013 report.[88]

177. Mr. Durber has precisely the kind of specialized, extensive and practical experience with both specialized pay equity mechanisms and general human rights laws to take on the task of investigating and analyzing whether the compensation of midwives is and was free of systemic gender discrimination.

178. Durber's expertise has been repeatedly relied upon by Courts and Tribunals and by the 2004 Federal Pay Equity Task Force which commissioned various research reports from him including on gender etc.[89]

3. Assistance Provided to Tribunal

179. Durber's evidence is the only evidence which the Tribunal has which comprehensively and in a gender inclusive fashion compares the work of midwives, CHC physician and CHC Nurse Practitioners in order to reveal their appropriate relative position since the 1993 relative positioning pay equity exercise conducted by the MOHLTC and the AOM.

180. The MOHLTC has not provided any version of such an analysis in this proceeding.

181. In addition to the evidence set out in this submission concerning the MOHLTC unequal treatment of midwives, Mr. Durber's three expert reports provide:

(a) extensive evidentiary support for the extent of and measure of the discrimination and compensation losses which midwives have suffered; and

(b) a baseline and evaluation mechanism and principles moving forward to monitor the work and pay of midwives and their comparators to ensure

---

88 "Examining the Issue of Equitable Compensation for Ontario's Midwives (November 24, 2013)," (Exhibit 194, Tab 1). See Annex 1 for Curriculum Vitae of Paul Durber.

89 "2004 Federal Pay Equity Task Force Report", Joint Book of Official Reports, (Exhibit 290, Tab 27) at p. 551.

midwifery compensation continues to be free of gender bias after the compensation adjustments made as result of this proceeding are made.

182. Durber is also the only job evaluation pay equity expert who is completely independent as various of the MOHLTC experts function as Ontario Government compensation advisors and negotiators (see below). Durber has no connection to the AOM, either before, during or after his evaluations and therefore is able to be of the most assistance to the Tribunal.

4. Approach as Independent Human Rights Investigator

183. Mr. Durber approached his task from the point of view of an independent and neutral human rights investigator, a role he is very familiar with in light of his years as the head of the Canadian Human Rights Commission's Pay Equity Unit.

184. Mr. Durber's report has extensive footnoted research evidence to support his report and his Annex 8 details the extensive bibliography references which he analyzed in the course of arriving at his conclusions.

185. As well, at the request of MOHLTC counsel, Mr. Durber provided all his extensive foundational documents which were provided to counsel in August, 2014**.**

186. Mr. Durber approached his task by being careful to work to the degree possible while ensuring human rights compliance, with the compensation setting approach or systems of the MOHLTC. This was an approach which the Canadian Human Rights Commission used as a starting point.[90]

187. As a result, Mr. Durber started from the work of the parties just prior to regulation with the Morton Report and the Joint Work Group process to engage in a process to establish the relative and equitable positioning of the midwife in the existing health care hierarchy. He also situated his analysis in the values and health care reform objectives of the MOHLTC which also were relevant to midwives and the CHC Physician and Nurse Practitioner comparators.

5. Initial Report

188. In summary, the main observations and findings of Mr. Durber's November 2014 Report include the following:

189. **Job Evaluations:** Having analysed and assessed the work using the detailed Equitable Job Evaluation Factor Plan, Durber concluded that that the jobs being examined array themselves as follows: the job valued most highly is the CHC family physician; next is the midwife (at 91% of the value of the CHC family

90 Testimony of Paul Durber, Transcript, January 24, 2017, at pp. 143-144.

physician), and third is the nurse practitioner (at 79%). The rating data is summarized as:

Evaluation rating in points

	Midwife	CHC nurse practitioner	CHC family Physician
Total Points	**664**	**576**	**732**
% of physician	**91%**	**79%**	**100%**

190. He concluded that the midwife position is and has been indicative of unequal treatment, given this disparity between the salary maximum of the CHC and Midwife positions. That is, instead of receiving 91% of the CHC family physician's salary maximum, they receive just 53%— which is a percentage value difference of 38%. Durber relied on Mr. Mackenzie to calculate the gender pay gap which is about 48% based on current calculations.

191. **Historical pay gap:** The gap between proportionately equal treatment and actual compensation for midwives also existed in the past, beginning at least within several years of regulation at the beginning of 1994, when their salary was situated by the Ministry with respect to market rates for other professionals rather than with respect to relative or equitable value. Durber assessed the ratio of midwifery work to the work of CHC doctors from January 1, 1994 - to December 31, 2012. He broke up his assessment into 3 year periods as follows:

(a) **Period of Review – January 1, 1994 to December 31, 1996:** the ratio increases from 65% [calculated solely on the basis of direct salary] of the salary maximum rate of CHC family physician to 81% as of January 1, 1997;

(b) **Period of Review – January 1, 1997 to December 31, 1999:** the ratio increases from 81% of the maximum rate of CHC family physician to 85% as of January 1, 2000;

(c) **Period of Review – January 1, 2000 to December 31, 2002:** no increase in the ratio, which remains at 85%;

(d) **Period of Review – January 1, 2003 to December 31, 2005:** the ratio increases from 85% of the maximum rate of CHC family physician to 86% as of January 1, 2006.

(e) **Period of Review – January 1, 2006 to December 31, 2008:** the ratio increases from 86% of the maximum rate of CHC family physician to 90% as of January 1, 2009;

(f) **Period of Review – January 1, 2009 to December 31, 2012:** the ratio increases from 89% of the maximum rate of CHC family physician to 91% as of January 1, 2013.

192. Durber also summarized the below points in his report:

(a) **Proportionate equal value**: “equal pay for work of equal value” does not restrict itself to the precisely equal, but also includes “proportionately” equal. In that way, there is equality generally for each point of value assessed for both the midwife and the CHC family physician. Proportional value is recognised in cases at both the Ontario and federal levels.

(b) **Areas requiring further study:** Durber notes that his report only assesses the "direct wages of midwives", which are captured in their salary. However Durber also notes that the "indirect wages" of the midwives, such as benefits, should also be assessed through an equity analysis.

193. Durber notes that for the purposes of his pay equity analysis, he analysed the amount of hours worked by midwives throughout the period as consistent with those worked in 1993. However, he points out that this aspect of compensation may not be adequately treated since a 2007 survey of work by the Association of Ontario Midwives, demands for non-clinical work during the period covered by this Report have increased to such an extent that a midwife’s basic course of care now requires about 10% more time than in 1993. This change should also be integrated into the funding formula and any adjustments due to wage gaps.

194. **Conclusions on comparators:** Durber finds that there are clear indications that the extremely female-predominant work of both the midwife and the nurse practitioner were historically stereotyped, subject to prejudices because of their association with women’s work and roles in relation to women clients, and continued to suffer from challenges due not just to their being newly regulated and in the process of integration into the health system. This history in and of itself requires that the Ministry have in place an equity process for careful, gender-sensitive review of the compensation of midwifery work, both at present and during the period since 1994. (The same, it should be added, would hold true for the nurse practitioner profession as found in the CHC.)

195. In contrast, Durber notes that male-predominant work has traditionally often been over-described and favoured in relative compensation. In particular the medical profession has been situated at the apex of health care professions. Durber concludes that to ensure equity and gender neutrality, the compensation of both the family physician at CHCs and the midwife needed to be considered together. Durber also notes that, as a conservative approach, he gave the CHC physician full credit for the highest demands in the job description or literature, including for births (intrapartum care) which it turns out they do not generally do.

196. **Invisibility of Women's work** He notes, because it is generally agreed that women mostly do different work from men, it has been possible to identify features of women’s work. They are often invisible and under-valued. These serve as markers to be carefully considered for ensuring that any approach to valuing work is gender neutral and makes women’s work (as well as men’s) visible.

197. **Under-valued features of midwifery:** There are a number of under-valued features of women's work that are especially significant to these jobs. They include communications skills (in interprofessional collaboration for example); interpersonal skills; having a client orientation; requiring practical experience; exercising fine motor skills (among physical skills), using organisational knowledge; and having to expend emotional effort. Many of these features are not captured by traditional means of valuing work. It is a further reason for believing that the market would not by itself have paid such work equitably.

198. **Literature Review:** Durber reviews extensive literature about systemic discrimination that has resulted in women generally being paid less than men for work of equal value. He concludes that while there has been specialise remedial legislation directed at discrimination in compensation practices (for example, the *Pay Equity Act* and the *Canadian Human Rights Act)*, and including of equality provisions in the constitution (*Canadian Charter of Rights and Freedoms)* and in human rights laws such as the Ontario Human Rights Code, the disadvantages suffered by women in the workplace have not disappeared.

199. **Expanded SERW of Midwifery Work since 1993**: Despite the stereotyping and sex predominance, both midwives and nurse practitioners expanded their scope of practice, with the midwives gaining early hospital admitting privileges after regulation at the end of 1993, and the nurse practitioners much later in 2012. (Nurses practitioners were not formally recognised as "extended" until 1998. The Morton Report references their predecessor as "senior primary care nurse/nurse practitioner".)

200. **MOHLTC controls Health Regime:** The primary health care policy regime applies to all three primary health care professions. This is clearly determined both by legislation and the Ministry of Health and Long-term Care. In Durber's opinion, the GNCS used in this analysis reflects the values of this primary health care framework and the values of the MOHLTC, as well as the standards of the professions involved in this study. By analysing policy and contractual documents, Durber concludes that the Ministry is widely accepted as accountable for the midwifery program, including funding formulas and compensation. The fact that Transfer Payment Agencies act for delivering the payments would not detract from the substantive role of the MOHLTC. The GNCS used is also appropriate to the policy framework of the MOHLTC as well as to the standards in the professions.

201. **Sex Predominance:** The sex predominance of the professions in question is clear in the cases of the midwife and the CHC nurse practitioner [at nearly 100% and 95% for nurse practitioners generally], which are also carrying out women's work and in the case of the midwife, for women clients. And if one examines the historical association of male-predominance with the role of physician, as well as the actual demographics in 1991 (the Census year closest to 1993), the family physician is also associated with male work. Therefore he concludes that the issue of equitable treatment in light of sex can proceed. It is notable, for example,

that the medical profession (including family physicians employed within CHCs) have a compensation agreement covering the profession with the MOHLTC. In addition, the family physician generally was 70% male predominant in and about 1993.

202. **Issues with Initial Documentation used**: The initial job documentation (1993) relied on by the Ministry omitted a number of features of work which were necessary to truly assessing and valuing the work according to pay equity principles (including applying the SERW criteria). This is despite the fact that there was sufficient evidence about the work from a myriad of other sources which would have made a full analysis of the work quite feasible. Since 1996 there has been sufficient information available to inform a comprehensive understanding of the work.

203. **Need for periodic maintenance monitoring and review:** Given the stereotyping and traditional compensation disadvantages experienced by women in the workplace, periodic maintenance, monitoring and review are particularly important to following good pay equity (and compensation) practice. It requires periodic review of salary relationships. Updating the picture of value is also in order given the development of the newly regulated midwife work and the midwifery program generally.

204. **Overall Conclusion:** Durber's overall conclusion is that in light of the work, and given the difference in sex between the occupations of midwifery and the family physician, midwives are not treated equitably or proportionately according to the value placed on their work nor the compensation they receive for it, and this has prevailed over the period since 1997 to an increasingly greater degree as the program and the work have developed and contributed to primary health care.

205. Durber's comprehensive initial report addressed the following areas:

(a) His methodology, which included his human rights framework; identification of sex predominance; process for documenting the work; sources of evidence; time periods for estimating the value of midwifery work and pay; understanding and an analysis of the work; choosing the approach to valuing the work (i.e, the GNCS) and; assessing equity and proportionality in value and compensation.

(b) Contextual Considerations: Commonality of “Primary Health Care” to all three professions; Historical indicators of stereotyping of midwifery and nursing work; The obverse stereotyping relating to the physician; The Key Characteristic of “sex”, its definition and presence and significance as a consideration for equity; Indicators for denoting occupations as sex predominant — midwives, nurse practitioners and family physicians; Steps in integrating midwifery into the Ontario Health System, and features of work; Emergence of the Nurse Practitioner Profession; and the CHC Family Physician and CHCs;

(c) Features of Work of the Three Professions and Equitable Compensation Analysis; The Organisation of Work: Elements of Work of Three Professions;

(d) Valuing work - Choosing a Valuing Approach; Choosing The Job Evaluation Plan; Describing and evaluating the work; and Rating the jobs by Factor and Over time;

(e) Compensation issues; and Framework For Considering Equitable Compensation.

206. The November 24, 2013 Report also included Annex 4: Appropriateness Of New Zealand Plan: Primary Health Care Values – Analysis of work and policies and 12 evaluation factors; Annex 5-A: Features Of Work — Community Health Centre [CHC] Family Physician; Annex 5-B: Features Of Work — Midwife; Annex 5-C: Features Of Work — Community Health Centre [CHC] Nurse Practitioner; Annex 6: Ratings By Factor; Annex 7; Evaluations Of The Midwife's Work — 1994 To 2013.

207. Durber's initial report was also supported by extensive documentation, including both extensive footnotes, Annex 8 Bibliography of References Consulted during research and extensive foundational documents.[91]

6. Response Report Dated March 31 2015

208. Durber in his March 31, 2015 response report makes 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. 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. For clarity, it is these revised percentages that form the subject of the AOM's request for remedy. The revised points are as follows:

91 "Durber Foundational Document List", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 34); "Durber Endnotes", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 35);

SUMMARY TABLE				MIDWIFE RATINGS		
Year:	**1994**	**1999**	**2002**	**2005**	**2008**	**2013**
TOTAL POINTS	**586**	**615**	**615**	**621**	**650**	**664**
% of Family Physician (732)	**80%**	**84%**	**84%**	**85%**	**89%**	**91%**

209. Durber focused on three main themes in his response to MOHLTC reports from Bass, Chaykowski and Kervin:

1. Missing Analysis in the MOHLTC Reports:

210. **Coherent human rights framework within which a sex/gender analysis of the issue of wage equality can be conducted.** Expert analysis needs to be grounded in a proper gender equality analysis in order to properly assist the Tribunal. As well, the sources relied on by the MOHLTC Experts are often partial, not clear and not consistent internally or between one Report and another.

211. **Inappropriate consideration for human rights/pay equity analysis in the Kervin and Bass Reports;** the Chaykowski Report analyses labour market and employment factors as an explanation for midwifery and physician pay without analyzing how gender impacts those labour market factors; Both Kervin and Bass use a limited view of the rules of the Ontario Pay Equity Act in some circumstances but disregard the overall framework of that Act which recognizes that there is systemic discrimination in compensation of women's work in Ontario which must be identified and redressed.

212. **Absence of gender equality/pay equity analysis to determine whether sex is a factor operating in the compensation of midwives:** MOHLTC reports do not conduct such an analysis nor provide any evidence of what the compensation-setter, the MOHLTC actually considered when setting the pay of midwives and CHC physicians over the period since 1994. The absence of a classical “employer” or “establishment” in this case is also not reviewed or adapted.

213. **The context for assessing gender equality in compensation is not set out.** The analysis demands an understanding of the gendering of the work. It is not sufficient, as the Bass, Chaykowski and Kervin Reports maintain, to look only at the detailed rules for “gender predominance”. As a result, the Reports do not show an appreciation for the underlying nature of the work and public policy reasons for a serious review of the compensation treatment of midwives. That midwifery work is women’s work is never acknowledged, nor is the importance of the highly gendered nature of the work considered an important factor in the

MOHLTC experts' analysis which argues that sex has not been shown to be a factor in the compensation of midwives' work.

214. **Major sections of the 2013 Report with respect to contextual understandings (Sections K-L) and substantial job content information and references and foundational documents provided to the experts are generally ignored in their Reports.** By and large, their analysis brings forward barriers to engaging in a gender equality analysis of midwifery compensation without presenting thorough and comprehensive assessments to provide an alternative view of the value and pay relationship between midwives and CHC physicians.

215. **A unified examination of the job content and value of work of either midwives or CHC physicians is not conducted in the Reports:** Aspects of the value are reviewed in the Reports although primarily in relation to physicians and often not grounded in the specific work of the CHC physician but in family physicians generally or obstetricians. As a result, one cannot conclude from any of the reports whether the work and pay of the midwife is in a proper relationship to the work and pay of the CHC physician.

216. **There is a lack of an appropriate and comprehensive understanding of midwifery work.** The MOHLTC Reports do not, by and large, address the complexity and scope of midwifery work. Durber views this as part of a pattern of the MOHLTC experts overlooking and possibly undervaluing of midwife work in their Reports.

217. **The Kervin Report does not track how the nature of the work of both positions is linked either to gender or to what should be valued.** As a result, Durber's observation based on best practices and research that the work must be made visible is not part of the Kervin critique. Similarly, the Bass Report misses most demands made on both the midwife and CHC physician. It is not possible to conduct a bias-free critique without making these links. Overlooking, rendering invisible and minimizing demands are at the root of the systemic undervaluing women's work and it is troubling that the MOHLTC has adopted these reports. As a result, it is Durber's view that no conclusion can be drawn from the analysis of the Reports that the work of the midwife is properly valued and paid free of sex bias.

218. **The actual nature of the specific pay gap alleged is not focussed on sufficiently in the MOHLTC Expert Reports.** This is a particular problem in the Chaykowski Report, where the analysis diverts from equal pay for work of equal value, in this specific instance for midwifery to considerations other than value that are more appropriate when seeking to explain the gender wage or pay gap in the Ontario labour market in general. All Reports find no way forward to deal with the issue of whether gender explains any part of the wages for midwifery in this case.

219. **Ultimately, what is missing in the critiques is a specific analysis of the compensation setting decisions of the MOHLTC with reference to midwives and the CHC physician or any other comparator they considered more appropriate.** Such analysis would have examined, for example, how MOHLTC decisions about compensation are made, or not made; and whether there is a systematic approach at the Ministry that is consistent with public policy promoting gender equality (including equal pay for work of equal value).

2. Other Key Problems in the Reports

220. Durber finds that key critiques in the MOHLTC reports are misdirected, ignore the facts and reasoning in his 2013 Report, do not correctly represent situations or lack the gender sensitivity and balance that the above points would have enabled.

221. **Kervin's view that Durber's Report undervalued CHC physicians' work first by ignoring the changes that had added to its complexity over the 20 years from 1993 to 2013 is misdirected**. The Report was clear, and reiterated, that the "current" (approximately 2012/2013) demands of the physicians' work served as the base for job value. Holding the value of the CHC physician at current value did not affect the current proportional relationship Durber arrived at and also served to underestimate, not overestimate the retroactivity compensation owed if accepted.

222. **Most of the detail of work features that are set out in Durber's 2013 Report or its numerous Annexes are ignored.** For example, the Chaykowski Report relies on some broadly stated "competencies" in his comparative analysis of midwife/physician work, but those are partial – particularly the reduction of the work to a few features in Chaykowski's Table 4.(p.73). A further example is the exclusive use of years of formal schooling and years of experience in the Bass Report, (pp.10-11) without addressing the full scope of the bodies of knowledge required in the jobs examined which is caught by the New Zealand Knowledge factor.

223. **There are numerous examples of the "ignored" factors on the midwife's side** including, to name a few: that the work set out by Morton in 1993 was in fact the "entry level" of the work, that it developed quickly over time and that the full range of work was not borne in mind in establishing the initial salary. It is also ignored that midwives are the only Ontario maternity care providers who attend home births.

224. **Among the "not properly represented" is the number of instances in which Durber extend the "benefit of the doubt" to the work of the CHC physician – for example that they are all involved in the full range of maternity care (particularly labour and delivery – "intrapartum" care) – which they usually don't do**; that they all are family medicine specialists, when many job

descriptions do not demand that certification as there may be some pre-existing general practitioners with sufficient equivalent experience. Durber expresses a belief that when his report is examined by the Tribunal, it will show that he acted as an independent expert consistent with his training and experience to appropriately and fairly capture and value the work of both positions.

225. **The MOHLTC reports often overstate the demands of CHC physician work or attribute work to the CHC physician which is not part of their functions:** e.g. the Bass, Kervin and Chaykowski reports assume that they are doing intrapartum care. However much is made in the reports about the greater risk of physicians when it is generally accepted that intrapartum care is one of the riskier aspects maternity care and this is generally done in Ontario by midwives and obstetricians.

226. **The MOHLTC reports do not paint an accurate picture of midwifery work and its skill, effort, responsibilities and working conditions.** This further serves to undervalue the work and not challenge the prejudices and misrepresentations of midwifery work which appear to have contributed to their inequitable compensation. For example, the Reports refer to midwives dealing only with “low-risk” pregnancies without acknowledging the complications and emergencies that can arise and the complexities of carrying out the midwifery model of practice. As well, the reports fail to note that family physicians also deal only with low risk pregnancies – that both refer higher risk cases to the obstetrician/ gynaecologist.

227. **Lack of gender sensitivity and balance is often apparent.** The Chaykowski Report, for example, maintains that the CHC physician can do everything that a midwife can do, but that the reverse does not hold true. There is no evidence of this, physicians cannot “dip in and out” of the intrapartum care part of maternity care. Physicians are required by the College of Physicians and Surgeons to only do the work they are competent to perform which requires an analysis of whether they have sufficient recent experience and training in a new area. They must perform at least five deliveries a year to receive compensation bonus from OHIP for doing deliveries, for example.

228. **The nature and extent of midwives’ qualifications are frequently downplayed in the MOHLTC reports.** In the Bass Report, for example, the years of formal education attributed to midwives do not include the mentorship New Registrant year (similar to 1st year of family specialist certification) nor the requirement subsequently to have a mentor. That not all midwives have the full formal education, but are still licensed as they have "equivalent" education and knowledge, is said in the Chaykowski Report to detract in unclear ways from the credit to be accorded to the work. The same analysis is not produced for the CHC physician (in terms of whether they in fact have the specialist graduate training he asserts they have). This is despite the fact that Chaykowski appended Job Descriptions for the CHC physician which show such family physician specialist certification is not always required and evidence produced by Ms.

Frederika Scarth in her affidavit disclosed that a substantial number of CHC physicians remain as general practitioners and this is also true of family physicians more generally in Ontario.

229. **The same lack of balance is displayed in the Chaykowski and Bass Reports around the issue of labour shortage**: analysis is given for the "physician" side, but the actual shortages that are well documented (and noted below) on the midwife side are not similarly analyzed. They were noted tangentially in the 2013 Report.

230. Durber observes that in gender analysis, balance is particularly important as lack of it is part of the dynamic of undervaluing and under-compensating women's work. He notes the lack of any reference to Annex 2 in his 2013 report that sets out the frequently overlooked or undervalued features of women's work.

3. Irrelevant or Untimely Matters in Reports

231. Finally, there are critiques whose relevance and timeliness to the issue of a gender equality analysis in this case is questionable, but which also reflect a failure to situate an analysis squarely into the contexts Durber noted in Sections E-L of his 2013 report. Notable among them are the following:

(a) A long series of analyses in the Bass Report about how compensation relationships once established can be varied as a result of collective bargaining and arbitration and adjudication decisions. It is Durber's understanding that those decisions did not include a gender or wage equality analysis as such inquiries do not form part of the legislated criteria for consideration.

(b) A lengthy analysis in the Chaykowski Report about choices made by midwives to work part time, take leaves, thus reducing their wages. (There is no corresponding analysis of whether CHC doctors also work part time in that role.). See Appendix 18 - Part Time Status is a Gender Equity Issue for an analysis of the gender bias in this approach.

232. **Analyses in the Reports about the qualifications of midwives as individuals rather than the position which is the focus of a human rights pay equity analysis.** The relevant analysis here is in relation to the work requirements not the human capital and labour market characteristics of individual midwives. Qualifications are relevant only as they relate to the work requirements.

233. **The use of "labour market factors" such as "bargaining strength" to explain, and by implication, to justify the differences in wages between the jobs being examined**. While bargaining strength might possibly be considered a factor to justify a pay difference, generally this is considered only after pay equity is achieved and is not considered an exemption at all under federal human rights law. (see s.8(2) of the *Pay Equity Act*) After an evaluation is complete a

compensation setter trying to justify any or all of a difference in compensation would need to show that the difference was actually attributable to bargaining strength and that such strength was not gendered.

234. Durber's 2013 Report did contain an analysis of reasons for exempting some or all of any pay equity wage gap between the two jobs, that is, “reasonable factors”. There no indication that the Experts took advantage of their relationship with the MOHLTC to question the Ministry as to whether such factors actually did cause the difference in compensation and whether the factor was applied without gender bias to CHC physicians and midwives. Had the analysis been more squarely situated in the context of wage equality, such questions and analysis might have been introduced into the Reports.

4. Use of New Zealand Equitable Job Evaluation Factor Plan

235. Mr. Durber also used a state of the art gender inclusive comparison system in order to carry out the comparison process. As a result of Durber's expertise, he became aware of the development of a publicly available system created by the New Zealand Government's Pay and Employment Equity Unit. This system, the Equitable Job Evaluation Factor Plan – Working Toward Gender Equity, 2007, attached as Annex 3 to his report, was especially designed to take account of international and domestic learnings on the appropriate design of such a tool to ensure that gender bias was identified and eliminated.[92]

236. The New Zealand Equitable Job Evaluation Factor Plan – Working Towards Gender Equity (NZ EJE) was developed as a result of recommendations from New Zealand's 2004 Pay and Employment Equity Task Force report. That report was aimed at developing and implementing multi-level measures with the overall objective to close New Zealand`s gender wage gap by addressing both pay and employment equity.[93]

---

92 See NZ Department of Labour “Equitable Job Evaluation Project Overview Report” (September 2009), (Exhibit 216); "New Zealand Department of Labour, Equitable Job Evaluation Factor Plan (2007)", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 16A); New Zealand Department of Labour, Equitable Job Evaluation, A User's Guide (2007)", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 16B); New Zealand Department of Labour, Equitable Job Evaluation, Questionnaire (2007)", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 16B); "Hyman, Prue. Pay Equity and Equal Employment Opportunity: Development Between 2004 - 2007 and Evaluation, New Zealand Journal of Employment Relations (Online); 2007; 32, 3; ABI/INFORM Global", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 16D); "Hyman, Prue. Pay Equity and Equal Employment Opportunity in New Zealand: Developments 2006/2008 and Evaluation. New Zealand Journal of Employment Relations, 2008, 33(3):1-15", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 16E); "Hyman, Prue. Pay Equity and Equal Employment Opportunity in New Zealand – Developments 2008/2010 And Evaluation", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 16F).

93 "New Zealand Department of Labour, Equitable Job Evaluation Factor Plan (2007)", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 16A).

237. Dr. Chaykowski agreed "that a multifaceted approach to closing the pay gap is desirable and necessary."[94]

238. The Taskforce recommended and the NZ Government agreed that a gender-neutral job evaluation tool would facilitate evaluation of jobs free of gender bias."[95]

239. The NZ EJE tool was then developed under contract by Wyatt Watson, an international job evaluation organization.[96] The tool is unique because it "researched national and international experience of features of job evaluation design and implementation which increase and mitigate the likelihood of gender bias. These gender neutral principles were used to inform the EJE development process.[97] Those experiences including those of Canada which had a Pay Equity Act process since 1988.

240. The NZ EJE tool is also unique because it was designed for various uses not just a system or organization wide job evaluation process: These uses included:

    (a) *stand-alone use of the tool as a job evaluation system for an organization or occupation;*

    (b) *a tool for reflecting on the gender-inclusiveness of other systems in use for whole organizations or units, or particular occupations; and*

    (c) *a tool for producing information about relative job values for use in bargaining and/or in claims for funding for remuneration that more fully and fairly reflects the value of jobs in female-dominated occupations.*[98]

241. Accordingly, this tool was particularly appropriate in this situation where it is necessary to determine if the remuneration of a single job, the female

---

94 Testimony of Richard Chaykowski, Transcript, March 30, 2017, at p. 107.

95 NZ Department of Labour "Equitable Job Evaluation Project Overview Report" (September 2009), (Exhibit 216), at p. 1. See also "Hyman, Prue. Pay Equity and Equal Employment Opportunity: Development Between 2004 - 2007 and Evaluation, New Zealand Journal of Employment Relations (Online); 2007; 32, 3; ABI/INFORM Global", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 16D); "Hyman, Prue. Pay Equity and Equal Employment Opportunity in New Zealand: Developments 2006/2008 and Evaluation. New Zealand Journal of Employment Relations, 2008, 33(3):1-15", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 16E); "Hyman, Prue. Pay Equity and Equal Employment Opportunity in New Zealand – Developments 2008/2010 And Evaluation", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 16F).

96 NZ Department of Labour "Equitable Job Evaluation Project Overview Report" (September 2009), (Exhibit 216), at p. 3.

97 NZ Department of Labour "Equitable Job Evaluation Project Overview Report" (September 2009), (Exhibit 216), at p. 4.

98 NZ Department of Labour "Equitable Job Evaluation Project Overview Report" (September 2009), (Exhibit 216), at p. 3.

predominant midwife performing midwifery services for the OMP reflects a gender inclusive value and pay free of sex bias.

242. Commercial job evaluation (JE) systems in Canada do not have this public interest objective as the state created New Zealand tool did which can be used without cost.[99]

243. Mr. Durber also concluded that the New Zealand EJE was gender neutral based on his own qualitative analysis of the plan.[100]

7. Critique of Tool By MOHLTC Experts

244. The AOM relies on the detailed response of Mr. Durber to the MOHLTC experts critique of the NZ EJE tool which the AOM submits is inaccurate and misinformed.

245. The evidence discloses that when the new politically conservative government took power in New Zealand in late 2008, the Pay and Employment Equity unit of Government was abolished and the New Zealand tool was no longer officially promoted although it remained available on the New Zealand government website. There is no evidence that this change was based on any flaw in the tool. Instead, the evaluation of the tool which was appended to Dr. Kervin's report provided that the tool was appropriate and effective.[101]

246. New Zealand economist and gender equality specialist Prue Hyman wrote extensively during the time that the NZ EJE tool was in use. In this series of articles by Hyman, there is no discussion of the tool being flawed, or that such flaws were the reason for its discontinuation by the New Zealand government:

> `*The Unit had provided tools and assistance including a Pay and Employment Equity Analysis Tool...The website developed by the Unit...remains active and gives a link to order the PEEAT...", which is the Pay and Employment Equity Analysis Tool, "the Equitable Job Evaluation scheme (EJE), and the Spotlight Skills Recognition Tool...all available free of charge to both public and private sector employers.*[102]

247. The MOHLTC experts took issue with the NZ EJE but to a degree that is higher than are put on other job evaluation tools. For example, Dr. Chaykowski

---

99 Testimony of Richard Chaykowski, Transcript, March 30, 2017, at p.129.

100 Testimony of Paul Durber, Transcript, January 25, 2017, at p. 286.

101 Testimony of Paul Durber, Transcript, January 25, 2017, at pp. 395 and 518.

102 "Hyman, Prue. Pay Equity and Equal Employment Opportunity in New Zealand – Developments 2008/2010 And Evaluation", Documents to Put to MOHLTC Witnesses, (Exhibit 279, Tab 16F) at p. 2. See also Testimony of John Kervin, Transcript, March 27 2017, at p.17 and p.22.

suggested that the NZ EJE should have been tested by a tool like the ones he provided in his report; and yet these are tools that are not referred to in Pay Equity Commission documents, or contained in any government document.[103] Dr. Chaykowski also tried to argue that the tool may not easily translate out of the country of New Zealand; he did so without evidence, and without acknowledgement that systems used by the Ontario government, such as Hay, have been used globally.[104]

248. The burden that the MOHLTC experts place on the NZ EJE tool is also higher than has been expected by Ontario`s Pay Equity Commission: Mr. Bass stated as follows:

in terms of your use of the Pay Equity Commission's tool, the Pay Equity Commission's tool was never tested, right? There is no testing of it?

A. No. It just came out from the Pay Equity Commission…

Q... the Equitable Job Evaluation tool came out from the government of New Zealand's equity people too?

A. That's my understanding.

Q. All right. Okay. So, it's a different standard I think that's being used here. The Pay Equity Commission's tool that we have looked at yesterday wasn't tested that anybody knew about, and they didn't monitor its use and yet people continue -- you continue to adapt it and use it, right?

A. Yes, with some success."[105]

249. As well, Dr. Kervin testified that he was unaware of the reasons for the NZ government cancelling the tool and that he based his assessment that the tool was flawed on what he saw in Mr. Durber's report rather than anything done by or provided by the New Zealand government.

Q. All right, but you're coming here to tell us it's flawed.

A. I am.

Q. So I'm just trying to understand what you're basing it on.

A. But that's based on my own judgment, not theirs.

---

103 See Testimony of Richard Chaykowski, Transcript, March 30, 2017; Testimony of Richard Chaykowski, Transcript, March 31, 2017

104 Testimony of Richard Chaykowski, Transcript, March 30 2017, at pp. 105 -106.

105 Testimony of Richard Chaykowski, Transcript, March 30 2017, at p.26.

Q…. you'll agree with me that this document doesn't tell us it's flawed, and, in fact, it tells us that -- the conclusion on page 17 says:

"There has been limited use of EJE to date. Experience in using the tool is that it can contribute to full and fair description and analysis of jobs, especially in service sector occupations." And I can go through a variety of other statements in it, but you'll agree with me it's not saying that it's flawed, don't use it?

A. Well, without reading it, I'm not sure I can agree with you, but from what you've told me, that certainly seems to be the case.

Q. Okay. Well, you're the one who attached it to your affidavit, Dr. Kervin.

A. But that was on the basis of my own assessment of what was in Durber's report.[106]

250. Dr. Chaykowksi, also was not familiar with the political circumstances surrounding the use of the NZ tool:

Q. And in terms of the timing of this as well, and I am just wondering if you were familiar with this, were you familiar with the process that was actually happening in New Zealand with respect to their efforts to close the gender pay gap through pay and employment equity strategies?

A. I did not follow that in detail.

Q. Okay. And are you familiar with the genesis of the Equitable Job Evaluation system in New Zealand?

A. I have not studied in-depth the New Zealand system."[107]

8. The March 31, 2015 Durber Report

251. The March, 2015 report also addressed specifically how Durber had adapted pay equity/human rights principles and processes to the midwifery context and a human rights framework and methodology.

252. The March 31, 2015 report also included Response To MOHLTC Expert Statements Re: Ratings And Work Details which included The Knowledge Skills Factor; Problem Solving Factor; Interpersonal Skills; Responsibility for Services

[106] Testimony of John Kervin, Transcript, March 27 2017, at p.112-113.

[107] Testimony of Richard Chaykowski, Transcript, March 30, 2017, at p. 102-103.

to People; Emotional Demands; Sensory Demands; Note on the Perspective of the Chaykowski Report.

9. January, 2017 Durber Report

253. The January 2017 Durber Report responded to the August 2015 MOHLTC expert reports of Bass, Chaykowski, Kervin and Graves comments on Durber's March, 2015 report and addressed the following:

(a) Areas Of Agreement, Disagreement and Clarification - Ongoing Failure To Adopt Human Rights Framework and Methodology; My Continued "Insistence" on a “Gender Based Analysis’; Ongoing Absence of Sex as Key Consideration in Equitable Treatment Analysis and the Impact of Limited Mandates and Focus of MOHLTC Experts;

(b) Ongoing Failure to Adapt Pay Equity/Human Rights Principles and Processes To Midwifery Context and the Ongoing Absence Of Contextual Human Rights Considerations;

(c) Identifying The Association Of Gender With Work at Issue;

(d) CHC Physicians As Suitable Comparators to Midwives;

(e) Valuing The Work – Responding to Chaykowski View It Is Not Possible: Pay Equity/Human Rights Job Evaluation is Appropriate; Differences Between CHC Physician and Midwifery Professions Do Not Make Pay Equity Comparisons Between Them Inappropriate;

(f) Responding To Chaykowski's Justifications Pay Differences Between Midwives And CHC Physicians; the Differences in Educational Requirements; the Market Conditions, Including Labour Supply Factors; and the Differences in Bargaining Strength;

(g) Choosing A Gender Neutral Comparison System and Weighting; Bass Red Cross Plan Inappropriate;

(h) Job Content Collection Of Information - Use of Research Based Approach Rather than Questionnaires and Committee; Critique of Information Sources; Understating and Undervaluing Midwives Qualifications; Ongoing Overstating of Physician Qualifications and Work; The Job Content in Graves Report;

(i) Rating The Work - Reviewing and Evaluating Job Content Information; Single Evaluator or Committee; Benefit of Doubt Often Given to Physicians; Sorethumbing; Knowledge Skills and Rating Over Time - The Value Gap since 1994;

(j) The Results And Comparisons - Job to Job Comparison; The Proportionate Value Process and Regression Analysis; Proxy Comparison Method;

(k) Compensation Issues - Total Compensation.

6. The January, 2017 Durber Report also included Annex A: Analysis of Bass Red Cross Job Evaluation Manual and Annex B: Weighting of factors: some examples with comments.

10. Overall Assessment of MOHLTC Critique of Durber Analysis

254. The AOM submits that the MOHLTC experts are misguided and misinformed in their analysis of the Durber report and the report remains a reliable, comprehensive and gender inclusive and sensitive analysis of the comparison of the work of midwives and CHC physicians and Nurse Practitioner's.

255. A key example of unfounded allegations of the MOHLTC experts relates to the assertion that Mr. Durber did not appropriately capture the work of CHC physicians despite his extensive description of that work in his report and Annexes and his research documents.

256. In addition, an evidence based analysis of Durber's report with the evidence of the CHC physicians and Drs. Price and Graves about CHC physician work shows that this allegation is completely unfounded. Attached as Appendix 14 – is a detailed account of How Durber Took Into Account Key Work Aspects Of CCH Physicians As Described By CHC Physician Witnesses And Drs. Price And Graves. It is just this kind of detailed analysis which is necessary when assessing work and evidence and which is often missing in the MOHLTC expert reports.

C. Mr. Hugh Mackenzie:

11. Summary of Experience and Evidence

257. Mr. Mackenzie prepared three reports:

(a) Midwives compensation in Ontario 1994 to 2013 Comparative analysis and implications of Pay Equity: November 22, 2013, Revised March 13, 2015[108]

108 Midwives compensation in Ontario 1994 to 2013 Comparative analysis and implications of Pay Equity: November 22, 2013; REVISED March 13, 2015 (Exhibit 222, Tab 2)

(b) Report Responding to Minister of Health and Long-Term Care Expert Reports: March 30, 2015 [109]; and

(c) Mackenzie Replacement Tables dated February 9, 2017 for Retroactivity Tables in Section D, Part 12 of the January 2017 Response Report[110] with updated compensation calculation estimates.

258. He also provided a further Table dated February 9, 2017 to replace Retroactivity Tables in Section D, Part 12 of the Response Report dated January 5, 2017.

12. Qualifications and Experience

259. Mackenzie has worked as an economist in Ontario for more than 40 years in a variety of different capacities in the private sector and at all three levels of government in the public sector. His experience include 20 years as Research Director for the United Steelworkers of America and 10 years as an economic consultant to unions and associations in collective bargaining and in interest arbitration. That work has included extensive and detailed analyses of pay structures and options for the implementation of complex job evaluation systems.

13. Evidence

260. Mr. Mackenzie provided an initial November, 2013 report which was revised in March, 2015 to reflect the revised points calculations of Mr. Durber. He also provided a report dated March 30, 2015 which responds to MOHLTC expert reports addressing his initial report. His initial calculations were based on CHC physician compensation which did not take into account their extensive incentive payments over the period from 2004 onwards. These payments were unknown to the AOM and AOM expert witnesses at that time). His January 2017 report therefore revised those calculations and the resulting equity adjustments and retroactive calculations owing. The January 2017 report also has additional information which allows for a better estimate of the calculations as well as an amount to address at least in part the equitable adjustment for rural and remote midwives by adjusting their supplement.

261. The retroactivity adjustments and interest owing are an estimate only. A proper accounting will be necessary based on compensation records in the possession of the Ministry to finalize the compensation losses owing to individual midwives.

---

109 Report Responding to Minister of Health and Long-Term Care Expert Reports: March 30, 2015. (Exhibit 222, Tab 3)

110 Mackenzie Replacement Tables dated February 9, 2017 for Retroactivity Tables in Section D, Part 12 of the January 2017 Response Report (Exhibit 222, Tab 4)

Midwives compensation in Ontario 1994 to 2013 Comparative analysis and Implications of Pay Equity: November 22, 2013; Revised March 13, 2015

262. In this analysis, midwives' actual dollar compensation (based on a standardized workload as 40 primary and 40 secondary courses of care) over the period 1994 to 2013 is compared with what that compensation would have been had midwives' compensation evolved in accordance with three alternative rules:

(a) Maintaining the relationship between midwives' compensation and the male comparator CHC physicians established by the Midwifery Funding Working Group (the Morton Report); and

(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.

263. Since the writing of this report, more information has come to light about the scope of CHC physician compensation. The calculations updating the above information, are reflected in Mackenzie's 2017 response report and are set out in Section 7 below.

14. Report Responding to Minister of Health and Long-Term Care Expert Reports: March 30, 2015

Responses to MOHLTC Expert Comments about Initial Mackenzie Report:

264. In response to the reports from MOHLTC experts, Mackenzie made the following observations

265. Mackenzie responded to critiques raised regarding his initial report.

(a) In response to Chaykowski's comments, Mackenzie denies that the basis used in his report to establish equivalent-to-full-time compensation for midwives is not "notional" but rather grounded in the understanding of the parties.

(b) Mackenzie responds to Chaykowski's criticisms by clarifying that the analysis employed by Chaykowski uses factors which are irrelevant to a job evaluation analysis.

(c) Mackenzie responds specifically to Chaykowski's assertions that pay gaps can be explained by labour shortages or bargaining strength.

266. In response to Bass's comments:

(a) He highlighted Bass's failure to distinguish between pay equity and normal collective bargaining.

(b) As Bass's analysis reflects different choices with respect both to compensation measures and their comparison with midwives' compensation, Mackenzie provided an explanation of the choices made in preparing his initial report. These include:

(i) comparator compensation measures (Consumer Price Index and average weekly wages and salaries of employees in the health and social services sector);

(ii) the measure used as the basis for the comparison (pointing out that Bass employs a mixture of normal percentage change comparisons and absolute level comparisons from which he extracts the irrelevant conclusions that midwives are paid more than the average worker); and

(iii) the time period measured (Mackenzie used a period starting in 1994, the year in which pay for midwives was formalized by the Government of Ontario whereas Bass used three different time periods: 1994 to 2014; 2000 to 2014; and 2006 to 2014);

(iv) Mackenzie emphasized that rather than using the scale maximum – the job rate – as the basis for comparison, Bass uses compensation for entry-level midwives (overstating midwives' pay relative to the normal basis for comparison);

(v) Mackenzie explained that Bass assertion that his "analysis indicates that Midwives' compensation levels are somewhat above a full-time NPs [nurse-practitioner] salary in an ONA bargaining unit" is not supported by Bass's data. Mackenzie critiqued the measures of compensation used by Bass and provides a breakdown of the Bass compensation analysis.

Observations In Response To Those Aspects Of The Respondent's Expert Reports Dealing With Job Evaluation:

267. Mackenzie highlighted a number of problematic aspects relating to job evaluation in the MOHLTC expert reports.

268. He confirmed that evaluation methodologies can and have been used to value jobs performed by professionals who are subject to externally administered professional standards and "competencies".

269. He responded to Kervin's use of factor weighting and concluded that Kervin's lengthy discussion of weighting factors raises a distinction without a real difference.

270. With respect to Kervin's report, Mackenzie responded to the critiques of Durber's assumption that the CHC Physician value for 2013 was constant during the Study Period of 1993 -2013.

271. Mackenzie concluded that in fact, Durber's assumption that the measured CHC physician's value for 2013 had remained unchanged throughout the study period actually serves to understate the amount of retroactivity required. Mackenzie also weighed in on the discussion of Job-To-Job Comparison vs. Regression Line Analysis.

272. Mackenzie concluded that although there is an infinite number of possible job lines running through the single job value / salary point for the CHC physician, the range of variation in the placement of the line is constrained and the proportional approach taken in the Durber Report results in the lowest job value consistent salary of any of the possible job lines running through the CHC job value / salary point.

Explained Revisions to November, 2013 Report based on Durber's calculations:

273. In response to the changes made by Paul Durber to his own expert report, Mackenzie submitted a revised version of his original report on March 13, 2015. In his response report on March 30, 3015, Mackenzie detailed the key revisions made to his original expert report.

274. The first revision was that the compensation implied by maintaining pay equity based on the Durber Report's re-assessment of the relative value of the work of midwives and CHC physicians as the duties and responsibilities of midwives evolved over the period 1994 to 2013 is 63% of the CHC maximum in 1994; 80% in 1997; 84% in 1999; 85% in 2005; 89% in 2008; and 91% in 2013.

275. The second revision was an updated analysis of midwives' actual pay vs. the pay equity formula used in the Durber Report. Mackenzie provided an updated graph of this analysis in his updated report. Accompanying this graph are various data charts and summary results that have been revised on the basis of the new information provided.

15. Response Report to August, 2015 MOHLTC Expert Reports of Bass, Chaykowski and Kervin and Updated Compensation Calculations: January 5, 2017

276. Mackenzie responded to the expert reports of Bass, Chaykowski and Kervin as follows:

277. Regarding the Kervin 2015 Report, Mackenzie:

(a) challenged Kervin's assertions with respect to employer and employee involvement in Pay Equity implementation, explaining the statutory mechanisms through which employees can provide input into subfactor weights.

(b) reasserted the rationale for his sensitivity tested subfactor weights, and noted the inappropriateness of Kervin's selective amalgamation of the Hay system and the New Zealand system.

(c) defended his decision to attribute to physicians the higher value work and its clarified impact

(d) challenged and undermined Kervin's critique of the wage line

278. Regarding the Chaykowski 2015 Report, Mackenzie:

(a) critiqued Chaykowski's claim that the differences in the terms and conditions under which midwives and CHC physicians participate in the health care system make a comparison of the two invalid; and

(b) critiqued the assertion that the differences in the relative bargaining power of midwives and CHC physicians is a legitimate basis for differences in compensation which should be taken into account in any relative value analysis.

279. Regarding the Bass Report, Mackenzie responded to Bass's critiques of his response report on the following categories:

(a) the distinction between collective bargaining and pay equity;

(b) the measurement of the cost of living and wage levels;

(c) the time periods over which comparisons should be made;

(d) scale level vs. scale progress in pay comparisons; and

(e) the issue of job regression lines.

16. Updated Calculations of Inequitable Compensation Treatment as of February, 2017

280. Mackenzie's February, 2017 chart reflects the updated salary data for CHC physicians. Taken together, Mackenzie's three expert reports and updated chart reveal a powerful picture of the financial impact of the MOHLTC's discriminatory compensation-setting system.

281. Establishing human rights pay equity effective 1997 and maintaining 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 equity analysis, the base salary for a full time midwife at the date of the application, (excluding benefits) should be $197,221; that is, the difference is $94,661 higher than the actual midwives' compensation at that time.[111] This is calculated at 91% of the total maximum compensation (base salary + on call funding) of the non-underserviced CHC physician.

282. Applying the Durber analysis to include benefits to both the midwife and CHC physician salary, the total compensation due to the midwives on the date of the application is $236,665, revealing a wage gap of $113,593.

283. Applying Durber's equity adjustment, the base salary (excluding benefits) for a full time midwife as of April 1, 2016 should be $189,689. This figure takes into account the recent reductions in CHC physician compensation. This figure is $87,129 higher than the actual midwives' base salary on April 1, 2016.

284. When benefits are included, this number becomes $227,267, revealing a wage gap of $104,195. Midwives current salary including 20% for the value of benefits is 123,072.[112]

285. The midwifery base salary in 2013 was $102,560. Had midwives' base salary been adjusted to reflect changes in the cost of living, as was provided for in the 1993 midwives' compensation Framework, midwives' base salary would have reached $110,600, an increase of $8,040 higher than the actual 2013 base

111 "Mackenzie Replacement Tables dated February 9, 2017 for Retroactivity Tables in Section D, Part 12 of the January 2017 Response Report" Expert Reports of Hugh Mackenzie (Exhibit 222, Tab 5).

112 "Mackenzie Replacement Tables dated February 9, 2017 for Retroactivity Tables in Section D, Part 12 of the January 2017 Response Report" Expert Reports of Hugh Mackenzie (Exhibit 222, Tab 5).

salary.[113] With benefits, using COLA increases only, the wage gap in 2013 was $9,648.

286. 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%.[114] That is, $77,000 in 1993 is worth $111,071 in 2013 dollars. Midwives have had a decrease in earning power of $8,511 in 2013 alone due to inflation.

287. 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.

288. From 1994-2013, not accounting for inflation, midwives' base salary has increased by 33%. Over the same period, the CHC physician maximum base salary has increased by 79.5%. The minimum has increased by more than 128%.

289. 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%.[115]

290. 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%.[116]

291. Mackenzie also added calculations to reflect the rural supplement. At each salary pivot point, the rural supplement is recalculated as a constant percentage of the urban midwife base. The percentage used in the calculation is 7.5%,

---

113 "Midwives compensation in Ontario 1994 to 2013 Comparative analysis and implications of Pay Equity: November 22, 2013; Revised March 13, 2015" Expert Reports of Hugh Mackenzie (Exhibit 222, Tab 2) at pp. 7-8.

114 "Midwives compensation in Ontario 1994 to 2013 Comparative analysis and implications of Pay Equity: November 22, 2013; Revised March 13, 2015" Expert Reports of Hugh Mackenzie (Exhibit 222, Tab 2) at p. 11.

115 "Midwives compensation in Ontario 1994 to 2013 Comparative analysis and implications of Pay Equity: November 22, 2013; Revised March 13, 2015" Expert Reports of Hugh Mackenzie (Exhibit 222, Tab 2) at p. 10.

116 "Midwives compensation in Ontario 1994 to 2013 Comparative analysis and implications of Pay Equity: November 22, 2013; Revised March 13, 2015" Expert Reports of Hugh Mackenzie (Exhibit 222, Tab 2) at p. 11.

approximately the percentage the rural supplement represented of the urban midwife base when it was introduced. [117]

17. Retroactivity

292. In his chart dated 2017, Mr. Mackenzie provides updated calculations on the total retroactive amounts due. The table below provides an estimate of the retroactivity owed by the Ministry to the midwives of Ontario. The purpose of the table is to provide a general sense of the amount owing. A proper accounting based on individualized compensation records in the possession of the Ministry will be necessary to finalize the actual individuals' compensation losses owing.

293. Hugh Mackenzie provided retroactivity estimates in a spreadsheet dated February 9, 2017.[118] The testimony reveals that the appropriate estimate would include a further reduction of 10% to those calculations.[119] The table below reflects this evidence.

294. Interest has been calculated in accordance with the Hallowell Methodology.[120]

295. As reflected in the table below, the estimated total amount of retroactive compensation losses owing to all complainants from April 1, 1997 to November 27, 2013 is **$342,182,548.**

18. Retroactivity Summary from April 1, 1997 to November 27, 2013

Retroactivity -- salary and equivalent		
Nominal amount owed to the date of Application (27 November 2013)		***272,795,296***
50% of nominal		***136,397,648***
Interest	***1.30%***	***1,773,169***
Retroactivity total		***274,568,465***

117 Response Report to August, 2015 MOHLTC Expert Reports of Bass, Chaykowski and Kervin and Updated Compensation Calculations: January 5, 2017 (Exhibit 222, Tab 5) at para 57.

118 "Corrected Spreadsheet, by Hugh Mackenzie, dated February 9, 2017" (Exhibit 230)

119 Testimony of Hugh Mackenzie, Transcript (February 13, 2017) at pp. 210-213.

120 Under the Hallowell methodology, retroactivity interest is calculated as follows: the nominal amounts owing are added; the resulting amount is divided by two; and the required pre-judgment interest rate applied (in this instance, 1.3%). The official interest rate table may be found at: http://www.attorneygeneral.jus.gov.on.ca/english/courts/4th_Quarter_2013_CJA_Pre_Postjudgment_Interest_EN.pdf

296. Mackenzie then increased allocation for benefits arising from applying 20% formula to all cash compensation.

Retroactivity – benefits		
Nominal benefits amount owed to the date of Application (27 November 2013)		***60,683,183***
50% of nominal		***30,341,592***
Interest	***1.30%***	***394,441***
Retroactivity total		***61,077,624***

297. Mackenzie then calculated the retroactivity for the rural adjustment, which would be added onto the compensation of some midwives to the extent that they were originally in receipt of the rural adjustment.

Retroactivity -- rural adjustment		
Nominal total		***6,494,246***
50% of nominal		***3,247,123***
Interest	***1.30%***	***42,213***
Retroactivity total		***6,536,458***

298. The total retroactivity amount—including benefits and accounting for annual proportion of midwives in receipt of rural adjustment.

Retroactivity – TOTAL		
Nominal total		***339,972,725***
50% of nominal		***169,986,362***
Interest	***1.30%***	***2,209,823***
Retroactivity total		***342,182,548***

D. Dr. Pat Armstrong

1. Reports

299. Dr. Armstrong prepared two reports: a) Initial report dated March 2, 2015;[121] and b) Report dated January 11, 2017 responding to the August 2015 MOHLTC experts reports.[122]

121 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B).

122 "Response Report to August, 2015 Ministry of Health and Long Term Care Expert Reports of Bass and Chaykowski, January 11, 2017," (Exhibit 254, Tab C).

2. Expertise and Experience

300. Dr. Armstrong is Canada's foremost expert in systemic gender discrimination in compensation and is the most widely referenced expert in such cases over a period of 25 years. Her work has been frequently cited by courts and human rights tribunals to assist them in understanding the context of the gender inequalities and discrimination women face in the labour market and the dynamics which render invisible and undervalued many key aspects of their work demands.[123]

301. Dr. Pat Armstrong is recognized as an 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. As reflected in her curriculum vitae,[124] Dr. Armstrong has also frequently written on the role of the state in the furthering or undermining gender equality for women in the labour market and specifically with respect to pay equity, systemic gender discrimination in compensation and developments in equity legislation.

303. As set out in Part C of her March, 2015 expert report, she has been qualified as an expert in the areas including the following:

(a) *P.S.A.C. v. Canada Post Corp***.** The Canadian Human Rights Tribunal: Tribunal accepted Dr. Armstrong as an expert in women's work, women's wages, and the sociological aspects of equal pay legislation. She testified about *inter alia* the history of "pay equity" and the methodologies used to implement that concept. The Union in that case alleged that the employer had violated the *Canadian Human Rights Act* by paying employees in a male-dominated group more than employees in a female-dominated group for work of equal value. First, the Tribunal relied on Armstrong's testimony when concluding that section 11 of the *Act* addresses "equal pay for work of equal value" between male and female workers. Second, it considered her testimony on systemic discrimination as a concept when it accepted that section 11 primarily addresses systemic discrimination.[125]

(b) *ONA v. Haldimand-Norfolk (Municipality:* The Ontario Pay Equity Hearings Tribunal relied on Armstrong's testimony to find that that wage discrimination was embedded in existing compensation systems, and that pay practices had failed to record or value differences between the skill,

123 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at p. 10-15.

124 "Pat Armstrong, Ph.D —Curriculum Vitae," (Exhibit 254, Tab A).

125 *Public Service Alliance of Canada v. Canada Post Corporation*, 2005 CHRT 39 (J12) – upheld by the Supreme Court of Canada, 2011 SCC 57, for the reasons given in the FCA dissent at paras. 218-222 and 247- 248.

effort, responsibility and working conditions required for women's as opposed to men's work.[126]

(c) *University of Windsor and Faculty Assn. of University of Windsor:* The Union argued that there was a pattern of systemic gender discrimination in salary figures because women were disproportionately affected by a supplementary salary fund. The grievance was allowed. The two expert witnesses included Pat Armstrong, who was qualified by the arbitrator as "an expert witness in matters involving discrimination against women."[127]

304. Armstrong has testified in almost every proceeding about the basis for laws which address the problem of discrimination in the compensation of women's work. Her testimony has traced the evolution of societal and academic understandings of the problem of occupational segregation and undervaluation of women's work Through her research and analysis she has traced the evolution of state mechanisms to address the problem while tracing the simultaneous development of research and policy understandings. In Canada, in this proceeding she started with the 1970 Royal Commission on the Status of Women and then moved forward through the 2004 Federal Task Force on Pay Equity Task Force report, entitled "Pay Equity: A Fundamental Human Right."[128]

305. A further important example of this evidence is a proceeding involving the respondent, namely the decision of Ontario Superior Court of Justice O'Leary in *SEIU Local 204 v. Attorney General.* which struck down Schedule J of the *Savings and Restructuring Act* repealing the *Pay Equity Act* proxy comparison method. Mr. Justice O'Leary stated:

> *"I accept the evidence of Dr. Armstrong, a renowned expert in the field of pay equity who swore two affidavits in support of the application*.[129]

306. Mr. Justice O'Leary Court relied on Dr. Armstrong's opinions that the proxy method was "introduced and implemented in a manner consistent with the original principles in the Pay Equity Act and properly identifies gender bias in valuation of women's work." In relying on her expertise in advising the Ontario Government with her report Pay Equity in Predominantly Female Establishments,

---

126 *ONA v. Haldimand Norfolk* (1991), 2 PER 105 (J2) at paras. 14, 18-19, 25 and 33.

127 *University of Windsor and Faculty Assn. of University of Windsor, Re,* 1990 CarswellOnt 4522, 18 C.L.A.S. 232 (J13) at para. 31.

128 "2004 Federal Pay Equity Task Force Report", Joint Book of Official Reports, (Exhibit 290, Tab 27).

129 Re Service Employees International Union, Local 204 et al and Attorney General of Ontario, (1997) 35 O.R. (3d) 508 (O'Leary J.) (J100) at p. 18.

Health Care Sector, the Court accepted Dr. Armstrong's analysis of the reasons for the legislation and implementation of the proxy comparison method.[130]

307. Gender equality is considered a universal human right. Considering the content of such rights and how to realize them is a subject of much legal and sociological study. In the field at issue here, a significant amount of that study has been conducted by Dr. Armstrong. Her book the *Double Ghetto,* and the *Working Majority: What Women Must do for Pay* are considered groundbreaking works in the area of the occupational segregation of women and the structures and dynamics which make women`s work in Canada so often invisible and underpaid. This has included the role of the state.

308. As Dr. Armstrong points out, government reports since the 1970 Royal Commission on the Status of Women up through the Ontario Green Paper on Pay Equity, her own 1988 report for the Pay Equity Commission commissioned by the Ontario Ministry of Labour [131] and up to the above-noted 2004 Federal Task Force Report have recognized pay equity as a fundamental human right and have discussed ways and means of realizing that right.

309. It is of course a separate legal matter whether there has been a violation by the MOHLTC established in this proceeding of the midwives' *Human Rights Code* right to equal treatment in compensation.

3. Assistance Provided to Tribunal

310. Dr. Armstrong in her reports and testimony 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.

311. 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 generally 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

130 Re Service Employees International Union, Local 204 et al and Attorney General of Ontario, (1997) 35 O.R. (3d) 508 (O'Leary J.) (J100)

131 P. Armstrong, *Pay Equity in Predominately Female Establishments: Health Care Sector*, Prepared for the Pay Equity Commission of Ontario (September 1988) in "Research Report I", Report to the Minister of Labour by the Ontario Pay Equity Commission, (exhibit 258).

any reasons for pay differences that are free of gender bias; 5) adjusting compensation; 6) ensuring that compensation free of gender bias is maintained.

312. Dr. Armstrong reflected that a comparison process with a specific male comparator may not always be required and notes the situation of women in predominantly female workplaces in Ontario who were directed by law to use a female job class in another organization which had achieved pay equity as their measuring stick and proxy for male work.

313. Dr. Armstrong noted that segregation of the labour force combined with the undervaluing of women's work as well as the need for action to remedy this discrimination has been recognized by the Ontario Government and Legislature. These factors are particularly obvious in the health care sector where care is an exemplar of women's work and men have traditionally remand at the top of the gendered health care hierarchy.

314. **Women and Midwifery:** 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.

315. Midwives are an exemplar of work done historically by women for women; work that calls out for an assessment of compensation that is free of gender bias. Midwifery is traditional women’s caring work but it now involves complex technical and diagnosing skills as well as the ability to work with families and other professionals in the medical hierarchy.

316. **Men and Doctors:** The historical exclusion of midwives from Canada's health care systems 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. The resistance to midwifery care did not and does not reflect the evidence. Resistance has not been based primarily on evidence but rather mainly on ideas about the value of this women's work. The eventual legal recognition of midwifery and funding in Ontario was a response to the demand from women who wanted to have midwives available to provide maternity care, from those who wanted to practice midwifery and from those who studied the evidence and realized that midwives provided safe, effective and cost effective services to women.

317. **Making Midwifery Work Visible:** In sum, the association of midwives with women’s traditional caring work in the home along with their exclusion from practice for a century and their continuing exclusion from some hospital and public medical insurance serves to render many of their skills both invisible and undervalued. Working with women rather than on women, largely without the highly valued technology used by obstetricians, midwives skills, effort, responsibility and working conditions are often invisible and undervalued. As a

result, there is a need for the government that sets their compensation to ensure that the compensation is free of gender discrimination.

318. **CHC Physicians Appropriate Comparator:** For a number of reasons, Ontario Community Health Centre (CHC) physicians are appropriate as a male comparator for midwifery. First, physicians have historically been men and this male domination and association with men continues even though significant numbers of women have moved into medicine. The fact that more women are becoming physicians and particularly CHC physicians hides the fact that men remain the most powerful teachers and supervisors in medicine, shaping the culture, values and evaluation of medicine. Men also dominate the associations that bargain wages and benefits for doctors. This historical and continuing male dominance continues to shape the evaluation and pay of physicians and makes physicians appropriate comparators for the purposes of assessing inequities between jobs traditionally associated with men and those traditionally associated with women.

319. **Permissible Justifications for Pay Differences:** Pay equity allows for differences in compensation that are based on factors that are free of gender-bias. This report addresses some possible justifications

320. **Labour Shortages Justification:** The differences in the continuing rise in doctors' pay compared to midwives cannot be primarily explained by supply and demand factors for two reasons. First, there is little evidence of an ongoing doctor shortage and doctors' income has continued to rise even as their numbers per capita have increased. There is considerable evidence to indicate that the supply of midwives does not meet demand while the supply of doctors outstrips population growth.

321. **Bargaining Strength Justification:** There are several reasons why bargaining strength does not provide a non-discriminatory basis for differences in the earnings of midwives and CHC family physicians. First, pay equity cannot be left to the bargaining table alone. Second, bargaining reflects occupational segregation which itself reflects historical prejudices and inequities and unequal and gendered power relationships. Doctors gained power and influence in part because of their gender. Conversely, midwives were long prevented from practicing except in the most remote areas, based on a denigration and denial of their skills that was in turn linked to their gender. Such a history has current implications for their strength in bargaining and their unequal power in compensation-setting. Third, systemic discrimination is pervasive and often unrecognized by all the players who have not trained in and focused on the factors that contribute to gender-based inequities. Fourth, high demand and low supply has not translated into bargaining strength for midwives while rising supply has made little difference to the bargaining strength of doctors. In short, there is a need to be suspicious of the bargaining strength explanation that does not take gender and gender history into account along with the unequal bargaining systems afforded by the Government to doctors and midwives.

Systemic discrimination is often reflected in bargaining strength, and on its own cannot justify pay inequities.

322. **Market Rates of Pay Justification:** Understanding pay equity as a human right means challenging what women's work is paid in the labour market. What is challenged by our international and national commitments to equal pay for work of equal value is the failure of the market to apply the same criteria to male and female dominated jobs.

323. **Midwifery and Pay Equity:** Dr. Armstrong notes Ontario midwives' earnings are set and paid by the Ontario Government. The Government is responsible for ensuring that this compensation is free of gender bias. While she notes that Ontario's Human Rights Code, like other legislation across Canada, disallows sex discrimination with respect to employment and/or conditions of employment or aspects of employment, she concludes that the human right to compensation free of discrimination does not depend on specific legislation.

324. To realize equal treatment with respect to employment requires that means must be found to provide pay equity to those not clearly covered by the Pay Equity Act. In Armstrong's opinion, this means applying evidence-based methods for addressing the equity of the earnings of midwives as set out in above.

325. In her January, 2017 response report, Dr. Armstrong addressed in detail the responses by the MOHLTC experts to her report. The AOM submits that she effectively addressed criticisms and reinforced the conclusions she reached in her March 2015 report.

326. As set out in Part 12 above, Dr. Armstrong's evidence are particularly of assistance in this matter where the Tribunal has not addressed before the specific issues and principles to consider in determining whether there is systemic gender discrimination in compensation setting mechanisms for a contractor position.

E. Dr. Ivy Bourgeault

1. Reports

327. Dr. Bourgeault prepared two reports: a) Initial report dated March 30, 2015;[132] and b) Report dated January 23, 2017 which responds to the August 2015 MOHLTC experts reports.[133]

---

132 "Expert Report of Dr. Ivy Bourgeault, March 30, 2015," (Exhibit 265, Tab B).

133 "Response Report to August, 2015 Ministry of Health and Long Term Care Expert Reports of Chaykowski, Kervin and Johnson, January 23, 2017," (Exhibit 265, Tab C).

2. Expertise and Experience

328. 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. Dr. Bourgeault is a medical sociologist and public health scientist with expertise in the fields of health professions, health policy and women's health. Dr. Bourgeault's expertise in gender, work and health human resources, with a particular focus on midwifery, nursing and medicine is recognized nationally and internationally. Her specific expertise in midwifery is based on over 20 years of research represented in the books Push! on the professionalization of midwifery in Ontario and Reconceiving Midwifery on midwifery integration across Canada.

329. Her extensive relevant expertise and experience are reflected in her Curriculum Vitae and her initial report.[134]

3. Assistance Provided to Tribunal

1. March 2015 Report

330. Dr. Bourgeault's March 2015 report provides extensive information, analysis and opinions with respect to the topics below which the AOM submits are of great assistance to the Tribunal in considering this matter:

331. **Explanation of sex/based analysis:** The tenets of a sex/gender analysis are to be cognisant of how sex and gender are two of the most fundamental source of differentiation we make of people; to be critical – that is, challenge assumptions and ideas of gender neutrality; be systematic – by applying this lens consistently and thoroughly and be transparent – report what is and what is not known. This is critical and relevant to this case.

332. **The gendered nature of the health care division of labour.** When one applies a sex/gender based analysis to the health workforce in Ontario, one realizes that one of the most neglected insights in health care policy has been that the healthcare division of labour is structured by gender and is permeated with complex gender dynamics. It is well established that social-cultural gender arrangements shape the structural location of men and women in the health workforce as well as the classification of caring and curing, formal and informal work, and skilled and unskilled work. The gendered arrangement of labour occurs both between professions as well as within professions. The dominance

134 "Ivy Lynn Bourgeault, Ph.D — Curriculum Vitae," (Exhibit 265, Tab A); "Expert Report of Dr. Ivy Bourgeault, March 30, 2015," (Exhibit 265, Tab B).

of the medical profession within the health care division of labour was achieved in part through the exclusion of women. Medicine is still very much a male dominated profession in spite of the recent and rapid expansion of a number of women into its ranks. Female health professions, such as midwifery and nursing, remain distinct and separate from the dominant medical profession, typically through the use of gendered ideology of women's societal role as 'carers' as opposed to 'curers', thus in a position of subordination. This also involves an under-valuing of the skills possessed by these largely female health professionals, reflective of the broader societal undervaluing of women's work.

333. **The structural embeddedness of medical dominance.** Lower status health professions, like midwives in Ontario, are numerically dominated by women and historically have had to negotiate their work as well as their integration and recognition within the health care system vis-à-vis the male and medically dominant health care system. The dominance of the medical profession and the lower status of female health professions are structurally embedded in multiple layers of legislation and regulation governing the health care division of labour that privileges the medical profession both in terms of policy and remuneration. In this structural embeddedness, gender clearly matters and must be accounted for in men and women's work in health care in Ontario. Gender also matters and is most certainly relevant in terms of the clients of midwifery care.

334. **The gendered history of midwifery in Canada.** A fulsome understanding of the historical evolution of the profession and practice of midwifery in Ontario must be situated within a broader gendered context of the health care division of labour in that Province. Gender matters and is most certainly relevant in terms of the clients of midwifery care – exclusively women - and the providers of midwifery care – almost exclusively women – as well as the approach to care. Midwifery evolved from a lay social movement, where midwives initially worked outside of the bounds of the legally sanctioned and publicly funded healthcare system to promote and attend women in childbirth at home, to a professional integration project where midwives would become part of the recognized, regulated and publicly funded health care system.

335. **The midwifery vs. medical model of care.** The midwifery model of care – which is centred on the principles of the normality of birth, continuity of care, informed choice and choice of birthplace – differs from the medical model both in approach and occupational model of practice. The midwifery model is less interventive, not reliant upon nursing care for labour support and requires a significant amount of time being on call. 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, are seen not as natural life processes but as critical illnesses which need to be managed and are only considered safe or 'normal' in retrospect. In both instances midwifery care and medical care practices overlap and are complementary, but should not be considered substitutable. The male and medical dominance of maternity care whereby obstetricians are the primary provider is yet another reflection of the

structural embeddedness of medical dominance describing the gendered nature of the health care division of labour more broadly.

336. **Evidence informed maternity care.** There is substantial high quality evidence supporting the safety of midwifery-led and out of hospital care. Indeed, It is the tenets of the midwifery model of care - continuity of care, informed choice and choice of birth place – that are identified as the key determinants of midwifery care being safe, effective and of high quality. Based on this evidence, key international health care practice organizations call for the broader promotion of midwifery-led continuity of care for women with low risk pregnancies.

337. **The broader context of maternity care human resources.** The broader context of maternity care human resources in Ontario, as in the rest of Canada, is a rapidly declining participation rate of family physicians in providing intrapartum care to women with low-risk pregnancies who are then largely referred to obstetricians, specialists in high-risk care. This also creates a system of expensive, obstetrician-led birth, in an exceedingly strained healthcare system. The incremental growth of midwives in the Province (and indeed the country) is not enough to accommodate this exodus. This has a number of implications for the sustainability of maternity care human resources, but it is also a significant challenge in fully implementing some of the recommendations from evidence-synthesizing organizations like the National Institute for Health and Care Excellence (NICE) that midwifery led continuity of care should be the primary system of maternity care provision. The current desire for more midwives on the part of the Ontario and other provincial governments can be seen as an exemplar of the desire for cheaper maternity care – a cost that is born by the often inequitable remuneration of midwives reflective of other female health professions.

338. **The caring dilemma associated with midwifery work.** Many midwives feel there is a tension between providing high quality care for their clients, particularly in accordance with the continuity of care element of the midwifery model of practice, and being able to maintain familial responsibilities. Despite this caring dilemma being a salient feature of midwifery practice, some work structures can be created to mediate this dilemma, including an appropriate case load and remuneration to match their model of care, and provisions for part-time work and time off-call. That is, there are supportive and evidence-based mediators to the challenges associated with the caring dilemma of midwives, including those of a remunerative nature. The need for more midwives in the Canadian maternity care system means that policy efforts to sustain midwifery practices should be seriously focused in this direction.

339. **History of medical vs. midwifery compensation.** From its inception as a regulated health profession in Ontario, there was an implicit recognition that midwives would be consulted and involved in the negotiations around their remuneration. That is, Dr. Bourgeault's research showed that midwifery representatives of the AOM were consulted, negotiations took place and a

resolution in the form of a consensus ensued. There was also 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); this was used to compare midwifery to other professions so as to best pinpoint their position relative to other positions such as physicians and senior nurses/nurse practitioners in Community Health Centres.

340. **Unequal Negotiations Process for Midwives:** Unlike for the medical profession, this direct labour negotiation process between midwives and the Community Health Branch of the MOHLTC was not written into regulations. As a result, contract negotiations between the Government through the Community Health Branch and midwives as represented through their Association (AOM) have not been as regular, transparent nor direct as has been afforded the medical profession. This could be seen as 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. That is, the medical profession has a legal structure in place (even thought this has evolved over time) around their remuneration that was in place before midwives came on the scene. Thus, in the contemporary era, gender continues to play a critical role in the relations between professions within the health care division of labour, particularly in the value of work and compensation and how tasks are shifted from 'higher skilled' and paid (i.e., medical) to 'lower skilled' and paid workers (e.g., midwifery), the latter group being predominantly female.

341. **Response to MOHLTC experts justification of pay gap between midwives and physicians:** In responding to the justifications used for the midwifery wage gap, with respect to the competitiveness of admission to and level of education between midwives and physicians, there is evidence that admission into the midwifery education program in Ontario is very competitive, the level of education resembles that of medical school. We know less about the debt loads of graduating midwifery students, but we do know that the mobility requirement of the clinical placement of the program is a unique and costly element of their education program. We also know that midwifery students are expressly discouraged from working part time while in their program, a means of offsetting the costs of their education.

342. **Ongoing Effect of Male Dominance of Medicine**: With respect to the veracity of the lack of a gender dimension to the differences between the professions of medicine and midwifery, due to the significant majority of physicians in training and newly practicing physicians (and family physicians in particular) being female (Price, 2014: 3), evidence has been brought to bear that more women in a profession does not eliminate continued gender bias within that profession. The dominance of the medical profession (and arguable the medical model of maternity care) was in place prior to women entering the profession and this

continues to have an impact through the structural embeddedness of medical dominance.

343. **Comparison of Work Life Balance Issues for Midwives and Physicians:** Both professions of medicine and midwifery experience work life balance issues and these are gendered. Despite these stressors associated with medical school, the attrition rate among medical student is negligible. By way of contrast, there are high rates of student attrition in midwifery education programs and the reasons for the high drop-out rates are related to the gendered nature of work-life balance issues both as a student and beyond training throughout their entire career.

344. **CHC Physician Comparator**: The main comparator used in pay equity assessments of midwives - physicians who work in Community Health Centres – for the most part work on salary according to a 9-5 type of work schedule; indeed this is the attraction to CHC work for many physicians, and female family physicians in particular. Most CHCs do not have on call intrapartum care requirements. This is a significant point of departure with the work life issues associated with the midwifery occupational model of practice.

PART 14: MOHLTC EXPERT EVIDENCE - PROVIDES SOME VERY LIMITED ASSISTANCE

A. Introduction

345. AOM witnesses and experts have highlighted in their affidavits, testimony and reports substantial inaccuracies, analysis and omission errors, stereotypes and prejudices in the MOHLTC expert reports. This is detailed in Part 15 below as well as in Appendix 11 - Affidavit Paragraphs of AOM Non Expert Witnesses Which Directly Respond to MOHLTC Expert Reports, and including the following Appendices: Appendix 15: MOHLTC Created Any Shortage Of CHC Physicians; Appendix 16:Use Of Bargaining Strength As Justification For Significantly Lower Pay Reflective Of Gender Bias; Appendix 17: The Erroneous "Substitution" Arguments Made By MOHLTC Experts; Appendix 18: Part Time Status Is Gender Equity Issue; and Appendix 19: Liability Insurance As Expense Not Compensation.

346. The AOM relies on the above-noted responses and testimony which fundamentally challenge the bases and relevance of almost all the analyses and opinions in the MOHLTC expert reports of Mr. Bass, Dr. Kervin, Dr. Chaykowski and for the most part of Dr. Johnson.

347. The AOM and its witnesses have a much larger area of agreement with the reports of Dr. Price and Dr. Graves as the AOM and Mr. Durber recognize that the CHC physician should be valued and paid higher than the midwife as Mr. Durber's analysis reflects.

348. At the same time, the MOHTLC experts, particularly in their writings prepared outside of these proceedings but also in their reports and testimony have made certain statements which support the AOM application and provide assistance to the Tribunal in that regard. The AOM in this submission and attached Appendices have reflected those statements where appropriate.

349. AOM experts also specifically stated in their reports where they were in agreement with MOHLTC experts.

B. Concerns re: Independence

350. In assessing the usefulness of the MOHLTC expert evidence, the AOM submits that the Tribunal should take into account the fact that the MOHLTC chose to retain experts to critique the AOM expert reports who had functioned and/or are functioning as retained advisors to or negotiators for the Government in its compensation funding role rather than experts who are completely independent of the Government. For example:

351. Mr. Bass has been and is currently a negotiator for the Government with respect to the OMA negotiations. He has also negotiated for the Government with its AMAPCEO employees;

(a) Dr. Kervin has also been advisor to the Government with respect to its compensation and job evaluation requirements at various times; and

(b) Dr. Price has also been part of the MOHLTC negotiating team with the OMA and has also functioned generally as a MOHLTC advisor.

352. Further, the AOM notes that the MOHLTC experts appear to have been most directed to critique the AOM expert reports rather than to provide their own independent analysis of the matters at issue in this proceeding. It also appears that they provided with very little information about the substance of the application and documentation about the actual compensation and funding setting processes and rationales used by the MOHLTC. As a result, often the MOHLTC expert reports speculate about what justifies the substantial pay difference between the midwives and the CHC physicians. Further Mr. Bass appears to have taken the entire section of his report justifying the compensation of midwives at around $192,000 from an MOHLTC document rather than it being his own analysis.

C. Robert Bass - Reports and Expertise and Experience

353. Mr. Bass prepared two reports: a) Report dated November 17, 2014 responding to the Durber and Mackenzie November, 2013 reports[135] and b) Report dated

135 "Expert Report of Robert Bass – November 17, 2014," Affidavit of Robert Bass, (Exhibit 280, Tab B).

August 17, 2015 responding to the March, 2015 reports of Durber, Mackenzie and Armstrong.[136]

354. The AOM notes that Mr. Bass restricts his practice to acting on behalf of management. He is not a neutral expert as Mr. Durber is. As well, Mr. Bass' expertise with respect to pay equity is based on his role as a management consultant. His role in that regard was the subject of critical comment by the Pay Equity Hearings Tribunal in the case of *Oakwood Retirement Communities* where the extremely high standards he says Mr. Durber should have followed in conducting a job evaluation were nowhere in evidence.[137]

D. Dr. Richard Chaykowski - Reports and Expertise and Experience

355. Dr. Richard Chaykowski prepared two reports: a) Report dated November 17, 2014 responding the Durber and Mackenzie November, 2013 reports[138] and b) Report dated August 17, 2015 responding to Durber, Mackenzie, Armstrong and Bourgeault.[139]

E. Dr. John Kervin – Reports and Expertise and Experience

356. Dr. John Kervin prepared two reports: a) Report dated November 17, 2014 responding to the Durber and Mackenzie November 2013 reports[140] and b) Report dated August 15, 2015 responding to the March 2015 reports of Durber, Mackenzie, Armstrong, and Bourgeault.[141]

F. Dr. David Price - Report and Expertise and Experience

357. Dr. David Price prepared one report dated November 10, 2014.[142]

358. There is not dispute generally with respect to the evidence given by Dr. David Price.. He did not provide particularly helpful knowledge to the Tribunal with respect to the work that CHC physicians do as he has not worked in a CHC

---

136 "Rebuttal of Mr. Mackenzie & Mr. Durber Reports – August 17, 2015," Affidavit of Robert Bass, (Exhibit 280, Tab D).

137 *Oakwood Retirement Communities Inc. v. S.E.I.U. Local 1 Canada*, 2010 CanLII 76245 (J107)

138 "Analysis of the Reports Supporting the Pay Equity Complaint by the Association of Ontario Midwives – November 17, 2014," Affidavit of Richard Chaykowski, (Exhibit 283, Tab B).

139 "Assessment of the Reply Reports of Mr. Durber, Mr. Mackenzie, Dr. Armstrong and Dr. Bourgeault – August 17, 2015," Affidavit of Richard Chaykowski, (Exhibit 283, Tab C).

140 "Fair Compensation for Midwives: Comments on the Report of Paul Durber – November 17, 2014," Affidavit of John Kervin, (Exhibit 278, Tab B).

141 "Fair Compensation for Midwives: Further Comments on Reports of Complainant's Experts – August 15, 2015," Affidavit of John Kervin, (Exhibit 278, Tab C).

142 "Expert Report of Dr. David Price – 10 November 2014," Affidavit of David Price, (Exhibit 288, Tab B).

setting. For further critiques of the affidavits of Dr. David Price, please see Appendix 11, titled "Affidavit Paragraphs of AOM Non-Expert Witnesses Which Directly Respond to MOHLTC Expert Evidence."

G. Dr. Lisa Graves - Report and Expertise and Experience

359. Dr. Lisa Graves prepared one report dated August 17, 2016.[143] In this report, she responded to questions posed by MOHLTC counsel.

360. There is not dispute generally with respect to the evidence given by Dr. Lisa Graves. She did not provide particularly helpful knowledge to the Tribunal with respect to the work that CHC physicians do, as most of her work as a family physician has been based outside of Ontario. For further critiques of the affidavits of Dr. Lisa Graves, please see Appendix 11, titled "Affidavit Paragraphs of AOM Non-Expert Witnesses Which Directly Respond to MOHLTC Expert Evidence."

H. Dr. Candace Johnson – Report and Expertise and Experience

361. Dr. Candace Johnson prepared one expert report dated August 17, 2015.[144] She was asked to critique the expert report of Dr. Bourgeault. She was not asked to respond to the Armstrong Report.

362. Dr. Candace Johnson did not provide any evidence that would assist the Tribunal in this case. She lacked even a basic knowledge of the regulatory structure of the midwifery profession in Ontario, compensation setting in Ontario, or the work of midwives. For further critiques of the affidavits of Dr. Lisa Graves, please see Appendix 11, titled "Affidavit Paragraphs of AOM Non-Expert Witnesses Which Directly Respond to MOHLTC Expert Evidence."

PART 15: THE INACCURACIES, ANALYSIS AND OMISSION ERRORS, STEREOTYPES AND PREJUDICES IN THE MOHLTC EXPERT REPORTS

A. Introduction

363. The substantial problems identified in the MOHLTC expert reports are both errors of commission but many reflect errors of omission and the lack of a gender based lens and inclusive analysis.

B. Critique by AOM Witnesses and Inconsistency with Government Documents and Evidence

143 "Expert Report by Dr. Lisa Graves – 17 August 2015," Affidavit of Lisa Graves, (Exhibit 272, Tab B).

144 "Expert Report of Dr. Candace Johnson – August 17, 2015," Affidavit of Candace Johnson, (Exhibit 274, Tab B).

364. The following AOM witnesses in their affidavits and testimony directly addressed those errors:

(a) Evidence of Katrina Kilroy

(b) Evidence of Kelly Stadelbauer

(c) Evidence of Vicki Van Wagner

(d) Evidence of Bobbi Soderstrom

365. For ease of reference, attached at Appendix 11 is "Affidavit Paragraphs of AOM Non Expert Witnesses Which Directly Respond to MOHLTC Expert Evidence", which sets out the text of that response analysis.

366. As well, Appendix 5, Overview Summary of Evidence by Chronological Eras Since 1994, and Appendix 13, Selected Excerpts from Various Government Decision-Making Documents including Cabinet Documents, also contain evidence which substantially contradicts the facts relied upon by the MOHLTC reports, and therefore renders invalid the conclusions reached and opinions provided.

C. Critiques of MOHLTC Experts by AOM Experts

1. Introduction

367. In addition, AOM experts, Mr. Durber, Mr. Mackenzie, Dr. Pat Armstrong and Dr. Ivy Bourgeault also specifically responded to the facts, analysis and opinions in the MOHLTC expert reports as they related to their own analysis. These responses, which substantially critique the reports are contained in their above-noted reports and are also reflected by topic in the Expert Comparison Charts at Appendix 10.

368. While the AOM experts do articulate some areas of agreement, they are of the view generally that much of the MOHLTC experts' views of the facts and their conclusions also contribute to the systemic gender discrimination in compensation suffered by midwives.

369. As noted above, since MOHLTC has adopted all of its expert reports as its position (see December 5, 2014 MOHLTC Response to AOM Request for Particulars), these inappropriate views have also been adopted by the MOHLTC.

370. The MOHLTC experts speculate as to why the Government paid doctors substantially more than midwife. They did not ask for or were not given access to government documents about what actually happened and their speculations are shown to be wrong, once the evidence is examined. This failure to properly investigate the actual facts and evidence reflects a gendered and systemic failure

to make visible and value midwifery work while over describing and valuing male dominated work.

371. For example, the MOHLC experts made invisible the differences in working conditions. One of the more profound job characteristics of midwives is 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.

372. The MOHLTC experts further contribute to the systemic gender discrimination by hypothesizing various key reasons to explain the significant pay 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; Courtyard in 2010 and Durber in 2013;

(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. See Appendix 16, Use of Bargaining Strength as Justification for Significantly Lower Pay Reflective of Gender Bias.

(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. See Appendix 18, Part Time Status as a Gender Equity Issue.

(d) A shortage of family physicians and the lack of substitutes for these physicians, although the evidence shows they cannot substitute for midwives and instead the government's plan is for midwives to substitute for the majority of family physicians who do not provide intrapartum care. See Appendix 17, The Erroneous "Substitution Arguments Made by MOHLTC Experts.

373. As detailed by Mr. Durber in his response report dated March 2015, none of the MOHLTC expert reports contain a pay equity/human rights/job evaluation analysis of midwifery work and any male predominant comparator.[145]

374. The MOHLTC has had more than enough time to carry out such an analysis and the failure to produce one or conduct one is just part of their ongoing discriminatory conduct.

375. The AOM submits that the Tribunal should draw a negative inference that such an analysis would not have supported the MOHLTC position that its

145 "Response to MOHLTC Expert Reports (March 31, 2015)," (Exhibit 194, Tab 2).

compensation is gender equitable. In fact, there is evidence before the Tribunal in government decision making documents post Courtyard report that there was no point in doing a further report as it would likely not result in anything less than the 20% equity adjustment Courtyard arrived at. (See Appendix 5)

D. Critique of MOHLTC Experts by Government Documents

1. Introduction

376. Further the MOHLTC pleadings and expert reports are not consistent with what Government produced documents state occurred.

377. 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.

378. See Appendix 13, Selected Excerpts from Government Produced Decision Making documents Including Cabinet Documents, which set out many statement which are inconsistent with MOHLTC expert factual statements.

PART 16: THE WORK AND SCOPE OF PRACTICE OF MIDWIVES

A. Introduction

379. Ensuring women's right to compensation free from sex discrimination starts with making sure their work is made visible and valued so that it can be compensated properly and equitably.

380. This section reviews 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 to highlight the demanding and skillful nature of the education, qualifications and work of the midwives This midwifery work along with CHC Physician and Nurse Practitioner work is also detailed extensively in the Durber Report and its various Annexes. Unfortunately, but part of the pattern of discrimination, the MOHLTC evidence did not focus on midwifery work but instead focused on physician work and the details of its greater importance.

B. Autonomous and Specialist Primary Health Care Provider

381. Like CHC physicians, midwives are autonomous Primary Care Providers. They are specialists in the provision of maternal and new born care.

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

382. Midwives provide midwifery care in accordance with the *Midwifery Act, 1991*[146] and the *Regulated Health Professions Act, 1991.*[147] The *Midwifery Act* sets 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*.

383. "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. In order to become a midwife, a physician or nurse must apply to and complete a very competitive Midwifery Education Program. They must complete the two-year program and the one-year New Registrant year.

384. The model of midwifery practice in Ontario is defined by the College of Midwives in a standard[148] 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.

385. 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 the 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 develop during pregnancy, labour, birth or postpartum, midwives work closely with specialist physicians and nursing staff.*
>
> *Informed Choice*

---

146 *Midwifery Act, 1991,* S.O. 1991, Chapter 31 (Exhibit 27).

147 *Regulated Health Professions Act, 1991,* S.O. 1991, Chapter 18, Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 91).

148 CMO Practice Standard, Midwifery Model of Care, (Exhibit 239) at p. 2-3.

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.

386. These principles are set out in the College of Midwives of Ontario Philosophy of Maternity Care.[149]

387. 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 can build a partnership, appropriate use of technology and evidence-based practice.

388. 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 Durber captured in his investigation and report and the MOHLTC and their experts ignored and/or did not understand or value appropriately.

389. 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:

149 College of Midwives of Ontario, “Philosophy of Midwifery Care”, Affidavit of Jane Kilthei, (Exhibit 1, Tab 60)

…….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." [150]

390. 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. Ontario's physician-led model does not have that requirement.

391. 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 newborn care by family physicians or paediatricians. Family physicians generally provide prenatal and post-partum care with only a small minority providing intrapartum care.

392. 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.

393. Demand for midwifery services in Ontario is high with MOHLTC stating that 35% of pregnant women in Ontario who seek midwifery services are unaccommodated.

394. The Midwifery model of care is also different from that of other healthcare professionals such as family physicians or obstetricians, who may care for female clients with regard to childbirth, but who do not operate within a model of care that is focussed on empowering women and engendering healthcare.

395. As noted above, family physicians generally provide prenatal and post-partum care with only a minority providing intrapartum care. 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

150 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], January 1, 1987, Affidavit of Jane Kilthei, (Exhibit 1, Tab 8)

start of the third trimester or refer to an obstetrician or midwife once pregnancy is confirmed.[151]

396. Community Health Centres provide maternity care to low risk women through a shared physician/nurse model assisted where appropriately by other CHC health professionals. CHC family physicians with some exceptions, do not typically provide intrapartum care. They refer patients with at risk pregnancies to obstetricians. As well, generally they refer low risk women to obstetricians at 28 weeks of pregnancy or to midwives or obstetricians at the time pregnancy is confirmed.

397. While ensuring constant access to a known midwife is 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.

D. Midwifery, the Model of Care and Women

398. Central to the midwifery 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 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.

399. 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.

400. As noted above, 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.[152] 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 connected to the women they provide care for, but is acutely tied to collaborating with women and addressing their health care needs and overall well-being which have otherwise been historically

151 See Testimony of David Price, Transcript, March 30, 2017 at p. 94.

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

undervalued. This historic undervaluing of women's health care needs was highlighted in the TFIMO report.

401. 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.

402. 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.

403. While the Tribunal heard from MOHLTC CHC physician witnesses 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 as it is embedded and required by law in the regulated model of midwifery care.

E. The Life and Work of a Midwife - A Demanding and Skillful Profession

404. The Tribunal heard extensive evidence from AOM witnesses concerning the life and work of a midwife and its demanding and skillful nature. See Appendix 8, The Life and Work of A Midwife – A Demanding and Skillful Job which sets out key selected quotes from the evidence of AOM midwifery witnesses who describe their working and family lives.

405. For a midwife to follow this difficult and onerous model of primary care, it 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 and unexpectedly being called to a labour. 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.

406. The AOM submits that Appendix 8 above should be read and compared with the CHC Physician's review of their work day set out in their testimony which includes fixed and regular hours, in the range of 35-40 hours per week with some on call work. The demanding nature of midwifery on call requirements is addressed in the next section.

F. Midwives' Exceptional and Undervalued On Call Requirements

1. Introduction

407. The on-call requirements of midwifery work are dictated by a) the needs of women for continuity of care, including the demands of intrapartum care; and b) the standards of the College of Midwives of Ontario which provide for the unique midwifery model of care. The MOHLTC has never undertaken an evidence-based analysis of the actual demands of on-call work so that they could be recognized in the remuneration system. Durber took these on call demands into account in his valuation of their work.

408. The MOHLTC experts reports do not differentiate between the working conditions of CHC family physicians and midwives with regards to the on-call requirements of the work. The Courtyard and Hay reports do take those differences into account.

409. ADM Nancy Naylor testified to the very visible working conditions of on call physicians, unaware that midwives have significantly more onerous on-call requirements than the ones she described during testimony:

> *"those contracts in a FHO model would require a physician to be available 24/7 to their patients. Now, practically speaking, this requires a group practice model because no human can be available 24/7. … So, a group practice of three would require -- would be required to offer three blocks of after-hours time during the week or on the weekend.*[153]

410. Dr. Price has written and warned about the dangers of inattention to monitoring and appropriately valuing demanding maternity care on-call work:

> *The provision of maternity care must be sustainable. Sustainability is more likely when practitioners have professional satisfaction, a balance of personal and professional commitments, and intellectual, emotional, and financial rewards… A final critical question is whether young physicians, nurses, midwives, and trainees in each of these professions will perceive providing maternity care as a realistic, exciting, and properly remunerated option and whether this will halt or slow the attrition of care providers. The ultimate goal is to provide high quality,*

[153] Testimony of Nancy Naylor, Transcript, November 3, 2016, at p.43.

competent care while allowing the maternity care provider to have a balanced life.[154]

Dr. Price has extended this caution to midwifery:

"Midwives regulated under new legislation are suffering under the same practice burdens that their physician colleagues have experienced, and they may soon begin to feel the same sort of burnout.[155]

2. Fewer Family Physicians Accepting Burden of Demanding On Call Work

411. The evidence reveals a very dramatic decline in the number of family physicians providing on-call intrapartum care and the CHC physicians testifying in this proceeding who do not provide such care are an example of this trend. Both MOHLTC expert witness physicians identified this trend and have been working to get family physicians interested and educated and trained to provide such care:

"Across Canada, the number of family physicians providing full maternity care has decreased over the last 2 decades, and the proportion providing intrapartum care has declined from 28% in 1990 to 13% in 2000, with one-third providing no obstetric care at all."[156]

"Q. And you also identify in this paper the reasons for decreasing family physician involvement in intrapartum care… And you say that they're well documented. It says: "The major factors cited include concerns about its impact on both personal and professional lifestyles, a lack of confidence in or concerns about adequate training, questions about sufficient reimbursement and for some, concerns about litigation."

A. Yes. Certainly in 2009 that was the landscape that we were dealing with, yes.[157]

---

154 Price, D. et al. "Maternity Care by Family Physicians: Characteristics of Successful and Sustainable Models" JOCG (May 2005), MOHLTC Expert Witness Documents, Volume 3, (Exhibit 279, Tab 83), at p. 465.

155 Price, D. et al. "Maternity Care by Family Physicians: Characteristics of Successful and Sustainable Models" JOCG (May 2005), MOHLTC Expert Witness Documents, Volume 3, (Exhibit 279, Tab 83), at p. 463.

156 Price, D. et al. "Maternity Care by Family Physicians: Characteristics of Successful and Sustainable Models" JOCG (May 2005), MOHLTC Expert Witness Documents, Volume 3, (Exhibit 279, Tab 83), at p. 460.

157 Testimony of Lisa Graves, Transcript, March 22, 2017, at p.116 -117.

412. Dr. Nicole Nitti, a CHC physician, testified to the reasons she stopped providing intrapartum care, giving insight to the tremendous challenge on-call intrapartum care poses to work-life balance and one's general health, especially to pregnant women, and women with family care responsibilities:

"… I was pregnant with my first child and I was also doing emergency medicine and, well, not inpatient care anymore, I was also doing emergency medicine shifts and I found that the unpredictability of the care, the nighttime calls were very difficult to manage because I was also working night shifts in the emergency room. So, it was very difficult to have nights off I found. And the way the call schedule worked, I found challenging and, to be honest, I found that I also needed to take care of myself. And so when I looked at my -- the broad scope that a family doctor can choose, right, I chose, I decided that, despite how much I love doing deliveries, I would focus on primary, like, a family practice and emergency medicine. So, that was a choice that I made." [158]

3. Demands of Midwifery On Call Work Different From CHC Physicians' On Call Work

413. The differences between midwifery and CHC physician work-life balance challenges were detailed by Dr. Ivy Bourgeault in her testimony:

"A. Midwives must do intrapartum care in order to be midwives. Full stop. Family physicians can continue to be family physicians and not do intrapartum care. Obstetricians/gynaecologists can choose not to do intrapartum care and continue to practice the gynaecology element of their OBGYN. So that is full stop…the reason why family physicians are not participating in intrapartum care is because largely work/life balance issues.

One could argue that the reason why fewer female family physicians are doing intrapartum care, one could talk about the gendered nature of their work, their work and their work life, you know, that they have and this is particularly during, you know, ages from, you know, 35 to 45, so childbearing, childrearing years for family physicians.

So in order to have better work/life balance, have much less disruption in your practice, not being called out for birth, not, you know, doing call for birth are choices that you can make and continue to practice as a family physician, and those choices are made, and those choices are made to balance, you know, their work and family life. So that's, you know, one element of the discretion that they have.

Q. And how does that compare to a midwife?

---

158 Testimony of Nicole Nitti, Transcript, November, 2016, at p.110.

A. A midwife cannot do that, all right? According to…the midwifery model of practice, again they must…provide intrapartum care. They must be on call. There are times…depending on where they work, and again, it speaks to the issue of working conditions, that they might be in a large enough group practice that that is more manageable, but they still have to be on call during certain times and at a birth of their clients that they have. It's part of their continuity of care model of practice."[159]

414. The MOHLTC physician witnesses provided insights during their testimony to the demands of an on-call lifestyle and about their own on-call schedules, demonstrating that the demands of the on-call family physician are significantly less that the midwife.

415. Dr. Price testified to the flexibility that a CHC physician has in determining their schedule:

"… one of the advantages to being a family physician is you can either you change your hours based on what your family dynamics or needs are. So, if you want to work 70 hours a week, you can do that, and if you want to organize it so that you can work 30 hours a week, you can do that as well."[160]

416. Dr. Price also testified to his working conditions as an on-call family physician providing intrapartum care:

"when I started with the maternity centre, I was doing one in three weekends on-call for the maternity centre. My pattern in my family practice was one in four weekends. So, I ended up working one in two weekends. And I could be gone all weekend and that, when you have any profession, is not sustainable long-term…."[161]

417. Dr. Macdonald provided testimony to the on-call requirements at her CHC:

"… I'm on call every Tuesday night and every, you know, about every sixth weekend I'm on call….

Q. Okay, and so you can be paged about a problem of one of the clients in the --

A. That's right.

Q. Can be, as I understand it. And does that require you to attend the person's home and provide care?

---

159 Testimony of Ivy Bourgeault, Transcript, March 21, 2017, at pp. 45-47.

160 Testimony of David Price, Transcript, April 4, 2016, at pp. 213-214.

161 Testimony of David Price, Transcript, April 4, 2016, pp. 223 -224.

A. Initially, it's a telephone call. So, you know, so we do as much as we can by telephone…. In the past, I certainly have gone out to people's homes….. I've gone on home calls at night when I knew the people are house-bound… And people that I know that are house-bound. I've gone on home visits when it's a single mother with a child and was having difficulty with transportation or getting out. So most, most, the norm would be a telephone call and with the occasional discretionary home visit if you decide that's necessary.

Q. So that's Tuesday night, and then some other time you said?

A. I split the weekends….

Q…so if there were six physicians, you're doing every sixth weekend?

A. Not exactly, because we share on-call with another local, another neighbourhood health centre, or neighbour health centre….. which is smaller. It's a smaller health centre, so we share. So it comes out to probably every six to eight weeks…It's for the weekend.

Q. And then what are you paid for that?

A. I can't remember exactly. We don't get paid per weekend. We get paid per year, but it's probably about -- it's about between $5- and $6,000 a year, something like that... It's a stipend for on-call.[162]

418. Dr. Woolhouse testified to the on-call work she is required to provide as a CHC family physician*:*

"A. …So I work .8, so I'm four days a week at South Riverdale, so that's 9:00 to 5:00 mostly on Mondays to Wednesdays, and then I'm 12:00 to 8:00 on Thursdays. … we're open three evenings a week and the physicians run a Saturday clinic. So that's a three-hour sort of urgent care clinic just for our patients. So we also have an on-call service, triaging service just for our patients, so once the day ends, one of us is on call and gets paged for any sort of urgent things, and then whoever is the on-call physician runs the Saturday clinic. So the only day we don't provide in-person care is a Sunday… so one week [on call] in seven. One week in six. Usually, there's always someone sort of away, but it's about that. That's what it averages to…so we're on call that whole week, so we carry the pager the entire week…And then run that Saturday clinic for three hours.

Q. And what would you be paid for that?

A. So the Saturday clinic, the time, I don't actually get paid for that. We get lieu time back. So I would take those three hours back at another point in the month,

---

[162] Testimony of MaryRose Macdonald, Transcript, November 9, 2016, at pp.194 – 196.

and I think it's about $300 per on-call week for that whole week of carrying the pager.[163]

419. Dr. Macdonald testified to how on-call coverage worked within the CHC sector:

"…it was quite variable how much on-call from centre to centre a physician was required to do. So, someplace that was very isolated, like Ignace, the physicians were on-call a lot…And someplace in Toronto the physicians that had a larger complement of physicians and that might pool their on-call among different health centres…you always had to do the on-call. It's just the amount of on-call. You didn't get paid more for more on-call.[164]

Q. And so intrapartum care would be part of that continuity. I'm just wondering why CHCs don't provide it.

A. I don't think we've had a large conversation at our health centre about why we don't provide it, number one, so we don't have a, you know, a strong philosophical stance. I think it's a complicated thing to add in, intrapartum care, you know, to your work in health. Depends on what the priorities of the work are… When you introduce intrapartum care into family medicine, then there's -- a big part of it is the scheduling issue, just, you know, being there or not being there, that type of thing.[165]

420. Bobbi Soderstrom testified to the stress of being an on-call midwife:

"...midwifery life is not an easy one. The midwife is on call 24/7 and, you know, yes, we work on call schedules and different schedules depending on the group that you work in, but when you're on call and it can be for long periods of time, you are not available and end up missing your kids' birthdays, you know, the illness that your mother is going through, and so on. That's just the natural stress."[166]

421. Elizabeth Brandeis also provided testimony to the challenges of being on-call:

A. When I began practising, I had a young child, a school-age child, and I was in a very fortunate situation having a partner who was a teacher, and so my partner's hours of work aligned well with my daughter's hours of school. I recognized that that was quite privileged compared to my colleagues who also had children and had very onerous expenses related to child care, often quite complicated child care arrangements, particularly for having on-call care providers for their children overnight. This was particularly true for midwives who

---

163 Testimony of Susan Woolhouse, Transcript, November 9, 2016, at pp. 116-118.

164 Testimony of Sue Davey, Transcript, November 2, 2016, at p. 62.

165 Testimony of MaryRose Macdonald, Transcript, November 9, 2016, at pp.192-193.

166 Testimony of Bobbi Soderstrom, Transcript, September 21, 2016, at p. 42-43

were single parents and didn't have another parent in the home to look after their children.

I made reference in my affidavit to a colleague who actually left the profession when she found herself facing becoming a single parent and chose to go to medical school and become a family physician instead of pursuing midwifery because of the higher pay and the lower on-call requirements.[167]

422. The most complete description of this on-call burden was provided by Maureen Silverman in her testimony:

"In order to be a midwife, I need to be on call 24 hours a day, 7 days a week for many periods of time, and that is extremely demanding, incredibly demanding, and quite disruptive to any kind of family life or social life, quite frankly.

So, I believe it's almost impossible for anyone who hasn't been on 24-hour call to actually know what that feels like or what that entails, but pretty much every part of my day is structured so that, if my pager goes off, and I need to be with a woman in labour or for any other reason that she feels urgently concerned, I need to be able to drop what I'm doing and go to that woman.

So, you know, I could be out shopping. I could be, you know, at an event with my children or my husband or other family members and it's just I just drop what I'm doing and I go.

So, it means I need to have food ready because when I go, I don't know how long I'm going to be gone for. So, it could be up to 24 hours. There is really no structured way of having breaks when we're midwives. So, it's not like I can run down to the hospital cafeteria and get some food. I need to have that food with me if I'm going to eat. I need to have clean clothes, uniform, etc. I need to have instant child care arrangements.

So, in the years when my family was young, this meant having all the arrangements, and I have four children. So, for drop off, pick up, you know, to school, to extracurricular activities, it's quite complex. Any time we would go anywhere as a family, when I am on call, we need to take two vehicles. So, even now when my children aren't living in the house with me, my husband and I have to go in two separate vehicles which is -- it's, you know, honestly, he's been living with me as a midwife for 20 years. He still doesn't get that part. It's very hard for him to understand it and he lives it.

So, that's a little snapshot of what it can be like. And I think that probably the hardest part for my family is that it's that constant uncertainty. They don't -- I'm not reliable. I'm constantly telling people I'm not reliable. Don't rely on me to do this or that, walk the dog, pick you up from the airport. It's like I always have to

---

[167] Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at p. 87.

say, yes, I'll be there unless I'm called to a birth. It's sort of the extra that I add onto every sentence.

And really the other aspect of it being the way I live my life is that the women that I care for are really number one. So, unless there is a family emergency, like, they are number two.[168]

4. On Call Midwifery Must Be Appropriately Valued and Paid

423. Only a small proportion of family physicians now provide intrapartum care and most of them practice in rural or non-city locations. To ensure women continue to receive on call intrapartum care, particularly in the home and in birth centre environment, it is necessary to have midwives provide this service. On-call work supports the availability of continuity of care, which supports positive clinical outcomes. On-call work also lessens the burden on already overworked emergency departments in hospitals, and prevents healthy pregnant women from having to travel and being unnecessarily exposed to infectious agents in a hospital.

424. There is no evidence that the MOHTLC has taken any of these client and system benefits into account in a systematic and evidence based way to determine the true value of the on-call service and the appropriate compensation for a midwife.

425. MOHLTC expert witness Dr. David Price has written:

"*Maternity care is rewarding, but it is also stressful. Those who provide maternity care (physicians, nurses, and midwives) need to feel valued for the work they do. Their professional contributions must be acknowledged by colleagues and by local and government administration in the form of adequate resources and appropriate remuneration.*"[169]

426. Dr. David Price testified to the need to appropriately value on-call work:

"And certainly when I was on -- not infrequently when you would be on-call for 24 hours, you developed a bond with that patient. And sometimes if you're absolutely exhausted, you'd wish the patient well and go home at the end of the 24 hours and they would be delighted that you were going because they got a fresh face. And other times you knew a delivery was imminent. You weren't tired and you knew you could have the judgment to be there and you would stay with them an extra couple of hours knowing that you weren't being paid for that "extra time", quote/unquote.

---

168 Testimony of Maureen Silverman, Transcript, October 18, 2016, at pp. 55-57.

169 Price, D. et al. "Maternity Care by Family Physicians: Characteristics of Successful and Sustainable Models" JOCG (May 2005), MOHLTC Expert Witness Documents, Volume 3, (Exhibit 279, Tab 83), at p. 465.

Q. … So, remuneration in general has an implication in terms of how you would be encouraging people to have a sustainable system?

A. Yeah. You have to create the kind of remuneration model that enables a sustainable call system, absolutely.[170]

Q. …And then finally it was the issue of recognition …you say here that: "Maternity care is rewarding, but it is also stressful. Those who provide maternity care, physicians, nurses and midwives, need to feel valued for the work they do. Their professional contributions must be acknowledged by colleagues and by local and government administration in the form of adequate resources and appropriate remuneration."[171]

427. Sue Davey testified that the CHC physicians receive an on-call stipend for their work that can be paid out but is not automatically provided. Previously, the CHC physicians, regardless of how much on-call they did, received the payment of approximately $5,000.[172]

428. Former AOM President Remi Ejiwunmi testified to the on-call demands of the midwifery model and how these were assessed by the Hay Group:

"And it also recognized that there was an allowance for the significant amount of time that midwives spent on call, which wasn't something that most CHC nurse practitioners or family physicians were required to do for significant lengths of time. It also recognized that a midwife's working week was longer than that of a family physician working in the CHC or a nurse practitioner working in a CHC.[173]

They had questions about the on-call hours, and that was because they felt that the number of on-call hours were flawed, but the thing that this doesn't take into account is that when you are on call for less time, so if you're sharing care with a partner, you are on call for more people…So if I'm a single midwife and I have 40 clients in care for the year, which is the typical number of clients that I provide care for, and I commit to them that I will be there for their births, I'm on call 24/7 for the entire year. If I'm sharing care with a partner midwife so that I get some time off call and she gets some time off call, when I'm on call, I'm now responsible for our 80 clients. So as the number of on-call hours decreases, the number of patients you're responsible for increases….And still it was determined that the on-call rate, which they felt was excessive, was in keeping with other comparators.

---

170 Testimony of David Price, Transcript, April 4, 2017, at pp.109 – 110.

171 Testimony of David Price, Transcript, April 4, 2017, at p.111.

172 Testimony of Sue Davey, Transcript, November 2, 2016, at p. 61.

173 Testimony of Remi Ejiwunmi, Transcript, September 28, 2016, at p. 46.

Q. And during this period of time, did you receive any analysis from the Ministry about how it thought the compensation should be evaluated?

A. No.[174]

429. Hay Consultant, Mr. Greengarten who has extensive experience as a compensation consultant testified to his review of on call component of midwives' work and compensation:

being on call is -- means you don't live your life as normal. It means there are restrictions on what you can do. There are limitations on what -- it affects your personal life. And so employers have for many years recognized that by providing for a fee, an amount of money to somehow offset, to recognize that there is that impact on people's personal lives as a result of being on call.[175]

430. In 2005, the Hay Group, under Mr. Greengarten's direction, undertook an analysis of the on-call rate paid to midwives to determine a reasonable, credible, defensible approach to compensating midwives for their on-call responsibility.

431. Mr. Greengarten testified to the unique on-call burden experienced by midwives:

"A…we found that the on-call responsibility is quite a lot more onerous than the on-call responsibility for Community Health Centre physicians…

"Q. … had you ever observed in your consulting practice on-call conditions similar to that of midwives?

A. No."[176]

432. Mr. Greengarten also testified to the challenge of determining an appropriate rate, because midwives work weekends, nights, holidays and these are typically recognized by employers at different and higher rates than weekday daytime work.

"… So it was difficult to get a handle and we came up with a number of $5 that we thought was reasonable. We subsequently were informed by the Association of Ontario Midwives that this was an area that the Ministry had questioned about. I can't recall if we saw the actual communication from the Ministry, but we were -- I think we were informed that the Ministry felt that that was a high number.

And so we, in our second report, we did review that number, and we came up with a lower number which, again, we thought -- we thought our first number was reasonable and was defensible, but we understood that it still was somewhat of a

---

174 Testimony of Remi Ejiwunmi, Transcript, September 28, 2016, at p. 50-51.

175 Testimony of Moshe Greengarten, Transcript, October 13, 2016, at pp. 27..

176 Testimony of Moshe Greengarten, Transcript, October 13, 2016, at pp. 27 – 28.

judgment call to say it's $5 versus it's $3, given all of the various factors. Now, today, you might be able to do a better analysis of those things than we could do at that time based on what was available, but we did come down to $3." [177]

433. Former AOM President, Carol Cameron testified to an attrition study she conducted with midwives, which uncovered a pattern of midwives of having challenges meeting the demands of the profession, and experiencing that they were not valued by the health care system. Her testimony also highlighted the risks of undervaluing midwifery work, and the toll it can take on a front line health care provider:

"Oh, wow. Okay. It was a hard study to conduct, honestly, and I had a really hard time getting through it.... It was really -- it was painful. .... I just found it hard to listen to people who had so much hope and so much to give and to feel the way they felt, that they kind of ran screaming from the profession. So personally, it was just really hard...The conclusions were that the job, the role, being a midwife was just, to sum it up, just too hard for many individuals...So they're people who invested a lot of time, effort and money into going to university to become something they felt passionate about, only to leave within a few years of -- because they couldn't cope with the work. Just they couldn't cope with the demands. They couldn't cope with the demand on their time.

And if you look at my literature, my conclusions, it was really about a loss of self, so they no longer recognized themselves, they gave too much of their selves, their time, their relationships with their family, the relationship with themselves, and just really, in order to survive and be a healthy person, they needed to give up the profession... all of these people were very passionate about providing care to women, providing care in the model in which we provide it. They keenly wanted to do that, and then because of just the reality of workload, they weren't able to do it, and the demands that it put on them and not being able -- not being valued, and the other big issue was trying to fit in to that health care system where they felt like an outsider, and the real wear and tear on them as a person... [178]

G. Midwifery – Partnered With Women To Address Women's Unequal Health Care

434. The growth of midwifery in Ontario in the 1970's and 1980's grew out of the concern of many women that their health care needs were not being fully met through the physician led model of maternity care. Ontario women experienced

---

177 Testimony of Moshe Greengarten, Transcript, October 13, 2016, pp. 29 – 30.

178 Testimony of Carol Cameron, Transcript, September 22, 2016, at pp.14 – 19.

unequal access and treatment with respect to their health care and particularly their care related to pregnancy, birth and the postpartum period.[179]

435. Women's organizations in Ontario were 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 was highlighted in the 1987 Task Force Report on Midwifery which lead the Ontario government to regulate and fund midwifery. It is also highlighted in the Van Wagner 1991 thesis: "With Women: Community Midwifery in Ontario."[180]

436. The Ontario Women's Health Branch was created to provide a focus on the need for equitable and appropriate health services for women. Given the connection of midwifery to women's health, the Branch was given the lead in the regulation process.[181]

437. Midwifery continues to be a key part of the Government's work in addressing women's health care needs. The ongoing issues of women's unequal health care have been addressed in a number of key federal and Ontario reports. Women have long reported that health care providers talk down to them and trivialize their complaints. As previously mentioned, the health system also has conferred on women's health processes a pathological status in situations where life conditions were natural. The biases of the health system affect not only users of services but also those who provide care.

438. The 2002 report by Dr. Karen Grant highlighted the process of "engendering health" or "applying a gender perspective on health" as follows:

"[…] the current understanding of gendered research (or what is sometimes called "engendering health" or applying a gender perspective on health) involves "examining differences in health needs, looking at differences between women and men in risk factors and determinants, severity and duration, differences in perceptions of illness, in access to and utilisation of health services, and in health outcomes. A gender approach in health, while not excluding biological factors, considers the critical roles that social and cultural factors and power relations

179 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], January 1, 1987", Affidavit of Jane Kilthei, (Exhibit 1, Tab 8); "Refining a Gender-Based Analysis for Ontario's Primary Care Reform Strategy, Project Report Prepared for ECHO: Improving Women's Health in Ontario (March 31, 2011)", Government Documents – Nancy Naylor, (Exhibit 151, Tab 5),

180 Vicki Van Wagner, With Women: Community Midwifery in Ontario, M.A. Thesis, 1991. Affidavit of Jane Kilthei, (Exhibit 1, Tab 16)

181 Testimony of Martha Forestell, Transcript, March 24, 2017

between women and men play in promoting and protecting or impeding health" (Ravindran 2000)."[182]

439. Incredibly, the MOHLTC December 4, 2014 Pleading in response to the para. 20 of the AOM's Schedule A states it "does not understand the allegation that midwives are "focussed on engendering healthcare."

440. Echo: Improving Women's Health, an MOHLTC appointed agency issued a report, Improving Women's Health in Ontario, and its Ontario Women's Health Framework which details the ongoing issues women face in having their health care needs addressed in the health care system and the need for a gender lens in policy making and analysis as a result. [183]

441. Further the MOHLTC Health Equity Impact Assessment Workbook, Version 2, 2012 [184] also highlights the need to assess the impacts of policies and practices on disadvantaged groups including women.

H. The Provision of Low Risk Care Still Involves Significant Risks and Complexity

442. It is generally accepted using the World Health Organization data, that approximately 70-80% of births in Ontario start out as low risk.[185] These would be eligible for care within the midwifery scope of practice.[186] The maternity care provided for these low risk births is carried out by midwives, obstetricians and a small proportion of family physicians.

443. Data shows that that majority of births attended by obstetricians are low-risk, even though they are trained high risk specialists.[187]

444. Both family physicians and midwives focus on low risk pregnancies with both making 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.

---

182 "Why Women's Health? Issues and Challenges for Women's Health Research in Canada in the 21st Century" paper prepared by K. Grant for the Women's Health Bureau (Health Canada) (December 06, 2002)", Affidavit of Jane Kilthei, (Exhibit 1, Tab 5).

183 Ontario Women's Health Framework, 2011, Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 25).

184 Health Equity Impact Assessment (HEIA) Workbook, (Exhibit 150).

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

186 BORN data from 2013 – 14, Affidavit of Jane Kilthei, (Exhibit 1, Tab 4)

187 Affidavit of Katrina Kilroy, (Exhibit 91), at paras. 113 and 129.

445. 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.

446. Midwives are trained to manage emergencies, including at out-of-hospital births. They deal with miscarriages and stillborn babies or babies who survive birth and then die.

447. 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).[188] 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.

448. 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 transfer of care to a physician in these cases even though a transfer is not medically indicated.[189]

449. 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.[190]

I. Education and Knowledge

450. 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.

---

188 CMO Guidelines; 2015-01-01 - CMO Guidelines - Consultation and Transfer of Care (January 2015), Joint Book of Legislation, CMO Standards, and AOM Guidelines at L323.

189 "OMP Hospital Integration Surveys, 2009 and 2011", Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 107).

190 Presentation of the MOHLTC to AOM re: Ontario Midwifery Program Evaluation (May 13 2004). Affidavit of Remi Ejiwunmi, (Exhibit 66, Tab 103). See Appendix 5 for further examples of this.

451. The Tribunal heard evidence from AOM witnesses about the scope and complexity of midwifery education which dispels 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 the midwifery education and knowledge base to the CHC physician education and knowledge base.

452. Vicki Van Wagner, the former head of the Ryerson, MEP gave extensive evidence concerning the development, implementation and evaluation of the MEP over the years since 1994. See Appendix 7, History of Midwifery – Suppression and Re-emergence of Female Predominant Profession, which contains a lengthy section on the development of the Midwifery Education Programme which is a highly regarded and very competitive academic programme.

453. 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 foreign trained doctors have been accepted to the MEP and some to the accelerated program.[191]

454. Although this point is never acknowledged by the MOHLTC's expert reports which criticize Durber's evaluation of midwifery education and 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).**[192] 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.

J. Midwifery Education Designed to Account for Gender

455. Midwifery education was designed to address the gendered nature of midwifery, it's almost exclusively female providers and the need to make the high level of education accessible to such women:

456. Vicki Van Wagner testified about this:

---

191 Affidavit of Vicki Van Wagner, (Exhibit 22).

192 "Reply Report to August, 2015 MOHLTC Expert Reports of Bass, Chaykowski, Kervin and Graves (January 3, 2017)," (Exhibit 194, Tab 3) at p. 40.

So we knew you could educate a highly skillful, competent, knowledgeable midwife, like the midwives in Scandinavia and in Holland, outside the university system. That would be possible… there had come to be a consensus that that was the appropriate status for midwives … we would need midwives to be educated in Ontario, in the Canadian cultural context, at a university level. So that established that. Should it be a Masters program? Midwifery in the U.S. is largely at the masters level, and so there was a debate about whether that could happen. We decided on a baccalaureate level for two… very equally important reasons. One was access, and we believed that the government at the time who we were collaborating with very much agreed with this, that in order for midwifery to be accessible to women, particularly women who may bring significant life experience as part of their credential, rather than simply years of education as their credential, that midwifery education at the baccalaureate level was very important, especially if we wanted to attract a diversity of midwives, which we very much wanted to do.[193]

One of the innovative and distinguishing things, though, that is different in midwifery than medicine is that the midwifery students follow the woman's care in a continuity of care, woman-centered model rather than being involved in episodic cases….family medicine and undergraduate medical students rarely have that opportunity to follow the woman's care through pregnancy, intrapartum and postpartum. That's a huge part of the learning of midwifery students and where midwifery skills come from.[194]

457. Dr. Armstrong testified about the woman-centred and family-centred focus of the education design:

And it's one of the reasons in midwifery, when they were trying to decide… that they were hesitant to go to universities with medical schools because they wanted to be able to practice … with the framework of continuity of care, of making it woman-centred and family-centred, and they were concerned that they would be swamped by the approaches in medicine if they went to a place with a medical school, and it was a big discussion within. So, when they went to Laurentian, there was no medical school there. When they went to Ryerson, there is still no medical school. They did go to McMaster but that was one out of the three.[195]

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

193 Testimony of Vicki Van Wagner, Transcript, September 16, 2016, at pp. 43 – 44.

194 Testimony of Vicki Van Wagner, Transcript, September 16, 2016, at p. 48.

195 Testimony of Pat Armstrong, Transcript, March 20, 2017, at pp. 154 - 155.

1. The Initial Standards and Guidelines Used to Set Compensation on Regulation

458. The Interim Regulatory Council of Midwives (IRCM), reporting to the Women's Health Branch in the early 1990's, 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.

459. 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 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.[196]

460. These Core Competencies were then 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.[197]

L. AOM Clinical Practice Guidelines

461. 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.

---

196 "Core Competencies: A Foundation for Midwifery Education - Recommendations of the MIPP to the IRCM, published by the Transitional Council of the College of Midwives, (March 1, 1993)", Affidavit of Jane Kilthei, (Exhibit 1, tab 62).

197 "Canadian Competencies for Midwives (Canadian Midwifery Regulators Consortium) Re Entry Level Competencies,(November 10, 2008)", Affidavit of Jane Kilthei, (Exhibit 1, tab 64).

462. 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.[198]

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

463. 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)

(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

198 See Joint Book of Legislation, CMO Standards, and AOM Guidelines re: 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.

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).

2. Current Scope of Practice, Guidelines and Standards

464. Midwives also have an ongoing obligation to ensure their midwifery practice is assessed and kept up to date.[199] In June, 2014, the CMO Council issued

199 See Joint Book of Legislation, CMO Standards, and AOM Guidelines re: 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; Affidavit of Bobbi Soderstrom, (Exhibit 32, Tab 36).

updated and consolidated Guidelines and Standards of Practice.[200] Mr. Durber took into consideration in his report those which existed in 2013.

N. Legal and Financial Midwifery Risks and Administrative Burdens Where Work Structured as Independent Contractor

1. The Risk/Reward Equation

465. Normally, an independent contractor would be paid more for this risk taking – more risk leading to more reward is a norm in Ontario society and a fundamental principle in every business school. In his report, Dr. Chaykowski acknowledges the important connection between risk and earnings although he uses this to show why CHC physicians earn so much more inaccurately stating that their work in higher risk than midwives.[201]

466. Midwives incur risk that CHC physicians, as salaried employees, do not and yet do not receive any additional compensation for this the way independent contractors normally would. As independent contractors there should be a premium for increased legal and financial risk and decreased security of income. This is not taken into account by the MOHLTC in their compensation setting.

---

200 See Joint Book of Legislation, CMO Standards, and AOM Guidelines re: 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).

201 "Analysis of the Reports Supporting the Pay Equity Complaint by the Association of Ontario Midwives – November 17, 2014," Affidavit of Richard Chaykowski, (Exhibit 283, Tab B), at p. 86.

2. Midwives Not Compensated for Increased Legal and Financial risks of Contractor Status

467. The MOHLTC expert witnesses did not recognize the additional legal and financial risks taken by midwives, nor did the MOHTLC assess this as a working condition of midwives in any type of systematic and evidence based assessment of the midwives' compensation. Instead, in cross-examining midwifery witnesses, MOHLTC was more interested in determining whether midwives obtained any profit from their practices. This, despite the fact that ensuring there was the capacity for profit and loss was precisely what the MOHLTC wanted when It designed the new devolved contractor system in 1999-2000.

468. The MOHLTC experts claimed physicians have more responsibility for risk and this accounts for part of the substantial difference in compensation. However, midwives bear unique financial and legal risk as independent contractors that salaried CHC physicians do not, and midwives should be compensated accordingly for taking on this risk; however, these risks are unaccounted for by the MOHLTC or its expert witnesses.

3. The Nature of Legal Risks

469. There are numerous legal risks carried by midwives that are not assumed by the CHC physicians, and are not accounted for in the compensation of midwives. These include:

(a) Midwives must fulfil legal contracts including the TPA-MPG funding agreement, the MPG rental agreement for space, the MPG's equipment leases, employment contracts with their administrative staff;

(b) The MPG and partner midwives must meet the obligations under various pieces of legislation that pertain to small business and health care organizations including: *The Accessibility of Ontarians with Disabilities Act, the Employment Standards Act* and numerous others. For example, Bobbi Soderstrom testified that the midwives had new obligations imposed on their practice groups (among others) once the Accessibility for Ontarians with Disabilities Act was proclaimed. Midwives had to become familiar with the legislation, ensure they were in compliance and are legally responsible to ensure they stay compliant. This is an obligation that the CHC physicians, as employees, do not have. This is an example of the kind of legislative requirement that midwives now have to comply with that they didn't have to comply with in 1993; [202]

[202] Testimony of Bobbi Soderstrom, Transcript, September 21, 2016, at p. 110.

(c) The risks of not being under *ESA* protection and, therefore, can be terminated from the practice with no severance (unless provided for in their partnership or associate agreement); and

(d) The risks of the practice being sued by a client (for non-clinical reasons such as slips and falls), or by an ex-staff member.

470. Ms. Soderstrom testified that:

"being an independent practitioner entails a whole lot of other things besides just compensation. I mean, if you look at running a business, Workers' Compensation not being applicable, insurance requirements, possibly employees, there are a whole lot of things that are involved in the world of being an independent practitioner that are not involved in the world of being an employee.[203]

4. The Nature of the Financial Risks

471. Midwives are not paid for the course of care and their operational expenses related to that course of care until after the woman is discharged from care (approximately 11 months after starting to provide care). There could be further delays in receiving their payment form the MOHLTC:

"Q. And the second paragraph says: "The decision to invoice at the time of discharge was taken by the Ministry." And let me just pause there. Meaning that the midwifery practice group would invoice the Transfer Payment Agency for the fees associated with the billable course of care at the time of the client's discharge.

A… we only invoiced once a month. So, it wasn't the day of a discharge an invoice would go in and a payment would be made. It could be several weeks before, in fact, that invoice would actually be submitted and then another small period of time before payment would happen….[204]

472. Midwives must wait for approval from the Ministry before booking their caseload for the year. Given the nature of pregnancy as a nine month long event that does not fit neatly into a government's fiscal year, MPGs are annually put in a place of intense vulnerability and risk, balancing the decision to go ahead and take women into care risking that their budget will not be approved and they will not get paid for the care they provide and work for free; or, turn away new clients risking that they will not be able to book a full caseload for the year (and take commensurate financial hit in their compensation). The budgets typically are not approved until months into the fiscal year putting midwives in a challenging position. This creates significant financial risk and job stress for midwives and

---

203 Testimony of Moshe Greengarten, Transcript, October 13, 2016, at p.31.

204 Testimony of Bridget Lynch, Transcript, September 23, 2016, at pp. 89 - 90.

increases the demand upon them for business management and financial skills. This situation and the risks it creates is not factored in at all into the compensation of midwives.[205]

473. This contrasts sharply to the salaried CHC physicians who are paid every 2 weeks or bimonthly – that is, within days of providing services. This delay in payment is not built into the compensation determination. In any other small business, a premium would be provided for a payment that is rendered more than a year after the first service is provided.

474. Other examples of financial risks that were invisible in the MOHTLC expert reports:

(a) The MPG-TPA Funding Agreement ensures the MPG is responsible for the funds provided by the MOH and has an obligation to pay these back under certain circumstances;

(b) The partner midwives are responsible for paying all members of the MPG, and responsible for statutory deductions for any employees; and

(c) Partners are required to take out loans, lines of credit to finance their practices while waiting for payment from the Ministry, especially during periods of growth.[206]

475. Soderstrom testified as follows:

"So, a lot of practice groups have the challenge of rental payments and payment for support services and the purchase of equipment and supplies and other expenses of running a practice -- of running a clinic that go beyond what the income is for any given year because they are dependent on that income on a per client basis. So, it depends on what your caseload is as to how much your income is going to be to run the practice. So, in fact, especially smaller practice groups have trouble making ends meet.[207]

5. The Stress of Legal and Financial Risks

476. The stress that is put upon an independent contractor responsible for the clinic and the health and welfare of their partners, associates and staff is very different than that of an employee. Dr. Nitti and Ms. Soderstrom shared the differences in this burden for CHC physicians and midwives, respectively:

---

205 See Testimony of Rebecca Carson, Transcript, March 10, 2017.

206 See Testimony of Rebecca Carson, Transcript, March 10, 2017.

207 Testimony of Bobbi Soderstrom, Transcript, September 21, 2016, at pp.159 – 160.

"I think that for both men and women [the CHC employee model] offers maternity and paternal leave…It offers, you know, if your child is sick, you can stay home. This is used by both men and women. And, you know, you are offered professional development support. You are offered vacation pay. So, these were the things that made -- that attracted me in terms of the financial aspect that I wouldn't have to spend my time doing running a business, right, and so that was my big reason for wanting to join.[208]

"*the advantage [to being an employee], assuming you have some kind of protection, and that varies from job to job and class to class I guess, is a security of your income. Your income tends to be fairly steady, whereas in the case of midwives not being employees, we're having -- and that goes to the question of budget and the discussion we had earlier about the stresses of being responsible for the business of the practice. In fact, every midwife needs to be concerned about what is going to happen should those budgets not be approved and should they not be approved in a timely enough fashion that we can plan caseload. It's a challenging way that we're set up to request money from the Ministry through a budget proposal when we don't actually get approval for the budgets well into the finance years. So, that would be one of the big differences I would say.*[209]

477. The CHC physician does not have to worry about the stress and timing of a budget, the potential laying off of midwives, the financial health of the practice group, the ability to pay members of its practice, staying compliant with all laws applicable to small practice groups and health organizations, etc. None of these stressors and risks are recognized in compensation by the MOHLTC, and have never been analyzed in a systematic and evidence-based manner.

478. When Morton created his report based on the conclusions of the Joint Working Group, the MOHLTC had not yet determined whether midwives would be salaried or contracted. In other words, this is factor that had not been considered at the time of originally setting the compensation of midwives, nor at any time since. Therefore the risks have been hidden from view, and undervalued.

479. Dr. Chaykowski criticized Paul Durber's report in his testimony, stating that Mr. Durber did not take into account the complexities of managing a midwifery clinic, implying that in this area, Durber underestimated the value of the midwifery work:

And they have other responsibilities associated with being in effect an independent contractor, and these can be very challenging to capture and that is fundamentally different than the situation for physicians because physicians are, of course, employees based in a particular CHC. Mr. Durber doesn't account for these kinds of complexities."[210]

---

208 Testimony of Nicole Nitti, Transcript, November 10, 2016, at p.112.

209 Testimony of Soderstrom, Transcript, September 21, 2016, at pp. 158 -159.

210 Testimony of Richard Chaykowski, Transcript, March 30, 2016, at p. 73.

"When we look at responsibility, the situation of midwives is also complex on that dimension. They are independent contractors and, as such, they have certain responsibilities which are somewhat unique to them, particularly with regard to their work within an MPG. The fact that they are independent contractors and yet are in effect running a small enterprise and have a certain degree of control and management responsibility over their own resources in a different way than employees might would potentially add a higher degree of complexity to the comparison…[211]

6. Midwives Not Compensated for Additional Administrative Burden of Managing a Small Business

480. Most midwifery practice groups in the province are able to hire one full-time equivalent administrator who can assist with reception, payroll, office management, etc. The larger practice typically have two full-time equivalent administrators. Yet, the bulk of the administrative work required to manage the practice, such as budget proposals, managing finances, performance management of staff, quality assurance, health and safety requirements, supplier management, etc., is performed by the midwives. CHC physician Dr. Woolhouse, on the other hand, described in her testimony an extensive administrative structure to within the CHC: an executive director; three program directors; under each of those directors would be managers; a medical reception team that helps with the functioning of the clinic; a human resources department, and administrative staff within that department.[212]

481. Katrina Kilroy described in her testimony this administrative burden:

"we have a caseload of somewhere between 500 and 550 courses of care, even 600… We have a hard cap at Mount Sinai Hospital of 300 births. So, I have actually spent time calculating. We ask people on intake whether they are planning to have their baby… Then we have to calculate on the basis of that information where do people actually end up having their babies so that we can get the right number of people from the right number of categories so that we end up with 300 births at Mount Sinai. It's really, really complicated. So, to have eight people trying to do that, ten people, twelve people would really not work."[213]

" our practice grew to be quite large and that work became very onerous and we spent many years thinking that we could divide it equally if we just had the right system, and we tried many systems to divide it equally and keep track of it, and eventually we just realized that it was too much and that it would be easier if we paid out of our own pockets one member of the practice to devote a certain

---

211 Testimony of Richard Chaykowski, Transcript, March 30, 2016, at p. 86.

212 Testimony of Susan Woolhouse, Transcript, November 9, 2016, at pp. 75 – 76.

213 Testimony of Katrina Kilroy, Transcript, October 6, 2016, at pp. 51 – 52.

number of hours every week to doing these tasks. So, that's what happened in our practice. We set up a job description for that and we came to call it "senior managing partner".[214]

"Q. And when you said that it's paid out of your own pockets, are you talking about the operation fees that are collected?

A. Maybe. The operational budget may not offer any -- there may not be any surplus in the operating budget to pay for that. We try to get it from the operating budget if we can, and if we can't, it comes from other sources. So, you know, we have a practice in downtown Toronto, a practice of 18 midwives. So, the operating budget is pretty tight."[215]

PART 17: COMMUNITY HEALTH CENTRES (CHCs)

A. Introduction

482. 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.

483. These Centres were created by the MOHLTC back in the late 1970's as part of its initial primary care reform initiatives.

484. In 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. 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.

485. 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.[216] Since 2004, the Centres have grown from 54 to 73 with many having satellite offices. Most of these locations are situated in the same local areas as midwifery catchment areas.

---

214 Testimony of Katrina Kilroy, Transcript, October 6, 2016, at p. 49.

215 Testimony of Katrina Kilroy, Transcript, October 6, 2016, at p. 50.

216 Dr. Chandrakant P. Shah and Dr. Brent w. Moloughney, "A Strategic Review of the Community Health Centre Program", May 2001. Expert Report of Paul Durber (Exhibit 194)

486. Between 2007 and 2011, CHC funding was devolved to the Local Health Integration Networks (LHINs). Since 2004, the compensation of CHC physicians is the only CHC compensation which is negotiated through the Physician Services Agreement (PSA) between the MOHLTC and the Ontario Medical Association (OMA), and whose funding is designated and protected.[217]

B. Community of Interest of Midwifery and Community Health Centres

487. Midwives, CHC physicians and nurse practitioners share a number of key factors – providing community based health care, working full time and part time and servicing vulnerable populations of Ontario residents and those without OHIP coverage such as refugees. At the same time, as noted above, midwives, unlike CHC physicians and nurse practitioners, are also responsible for the management of their clinics whereas the Ministry provides separate funds and resources to the CHC for to carry out that function.

PART 18: SEX/GENDER PERMEATES ONTARIO'S HEALTH CARE AND MATERNAL AND NEWBORN CARE SYSTEM

A. Introduction – Gender, Work and Occupations are Interconnected

488. As both Dr. Armstrong and Dr. Bourgeault have testified and as noted above by Dr. Armstrong "gender matters" and permeates Ontario's society, economy and health care system. As Dr. Bourgeault states in her report:

> *When one applies a sex/gender based analysis to the health workforce in Ontario, one realizes that one of the most neglected insights in health care policy has been that the health care division of labour is structured by gender and is permeated with complex gender dynamics. It is well established that socio-cultural gender arrangements shape the structural location of men and women in the health workforce as well as the classification of caring and curing, formal and informal work and skilled and unskilled work.*[218]

489. Accordingly, any compensation setter for that health workforce must identify and root out those complex gender dynamics so that they don't result in women's health care work associated with women being paid less than comparably or proportionally valued work associated with men.

B. Extreme Systemic Sex Segregation by Occupation and Sector

---

217 "Community Health Centres in Ontario" Accreditation Canada, www. Accredation.ca, prepared by the Primary Health Care Branch, Negotiations and Accountability Management Division, MOHLTC, Government Documents- David Thornley (Exhibit 179, Tab 57)

218 "Expert Report of Dr. Ivy Bourgeault, March 30, 2015," (Exhibit 265, Tab B) at para.7.

490. In analyzing the evidence, 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.

491. 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, government documents, CIHI Data charts,[219] the expert reports of Mr. Durber, Dr. Armstrong, Dr. Bourgeault, Dr. Johnson and the statements in Government documents referred to in Appendix 13 as well as the Government's Gender Wage Gap Review Committee Background Paper.[220] Dr. Armstrong specifically documented in her report through Charts, (various set out below) the highly gendered nature of Ontario's health care professions, with women dominating lower paying work and physicians dominating the higher paying work.

492. Statistic Canada stated in 2013 that despite progress, Canadian women remain concentrated in traditional female occupations.[221] Dr. Armstrong provided the Tribunal with evidence of the presence and persistence of occupational segregation:

> *In 2009, 67% of all employed women were working in teaching, nursing and related health occupations, clerical or other administrative positions, or sales and service occupations. This compared with 31% of employed men.* [222]

493. As the International Labour Organization points out, the significant gender disparities in women's pay "continues despite striking advances in women's educational attainments and work experience". [223]

494. According to a 2012 Statistics Canada report on women in Canada, "when women and men working full-time, full-year are compared, women's earnings remain at about 71% of men's, a ratio that has fluctuated between 70% and 72% since 1999. … In explaining it, the studies conducted since Sylvia Ostry's work for the 1970 Royal Commission have only been able to explain some of the wage gap in terms of factors usually considered free of gender bias. And as Ostry put

---

219 "CIHI physician gender distribution charts (1978- 2014)", Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 21).

220 See Closing the Gender Wage Gap: A Background Paper, Ministry of Labour (October 2015), (Exhibit 148); "OMP Hospital Integration Surveys, 2009 and 2011", Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 107).

221 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para. 62.

222 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B)

223 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para. 63.

it, it is clear that some portion of the residual differential stems from discrimination."[224]

495. 48.4% the labour force (both employed and unemployed) are female. Women make up 80.1% of the Ontario health care workforce.[225]

496. Dr. Armstrong provided data that showed a significant difference in average and median earnings for men and women in health care occupations. She also testified that this data showed a similar pattern to that of the Background Paper to the government's Gender Wage Gap Strategy, with a "huge wage gap and there is segregation with men on the top and women on the bottom, and most of the in between is women.[226]

497. Dr. Armstrong testified:

The segregation of the labour force and the accompanying undervaluing of women's work is particularly obvious in health care, as I have established in multiple publications such as A Working Majority: What Women Must Do for Pay and Critical to Care; the Invisible Women in Health Services – including in my report commissioned by the Ontario Pay Equity Commission; Care is an exemplar of women's work. Men have traditionally, and remain, at the top of the health care gendered hierarchy. The gendered division of labour within the health system reflects the gender division of labour within society." [227]

498. The government's own background paper for the Gender Wage Gap Strategy states:

Women in 'health occupations' (80.1% women) experience the widest gender wage gap at 46.7% or $43,582"[228]*.* The gender wage gap *"indicates a level of segregation within the occupation category*."[229]

499. Dr. Armstrong provided two important figures to illustrate the gender wage gap in the healthcare workforce. Figures 1 below indicates using average annual

---

224 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para. 63.

225 Closing the Gender Wage Gap: A Background Paper, Ministry of Labour (October 2015), (Exhibit 148) at p. 19

226 Testimony of Pat Armstrong, Transcript, March 20 2017, at p. 199.

227 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para. 88.

228 "Closing the Gender Wage Gap: A Background Paper", Ministry of Labour (October 2015), (Exhibit 148), at p. 19.

229 "Closing the Gender Wage Gap: A Background Paper", Ministry of Labour (October 2015), (Exhibit 148), at p. 38.

earnings, the gender wage gap in Ontario health care occupations has not improved much over the years.[230]

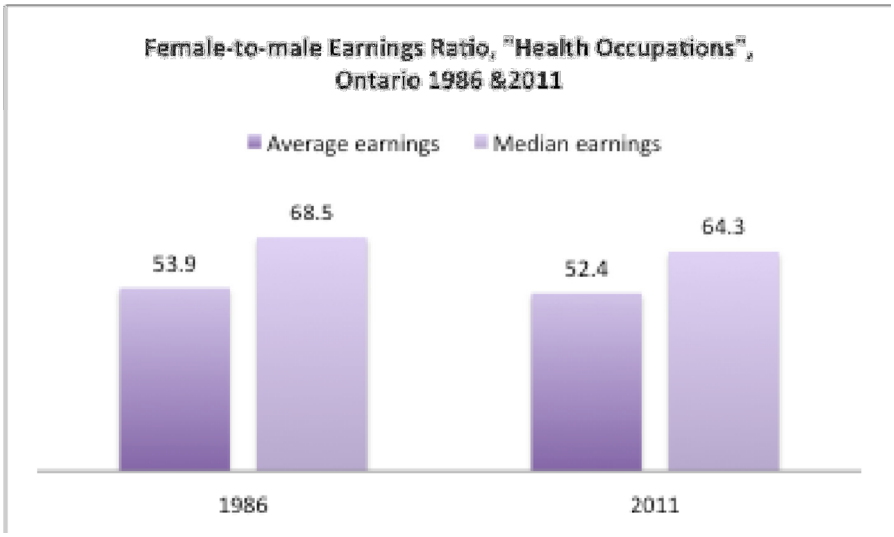
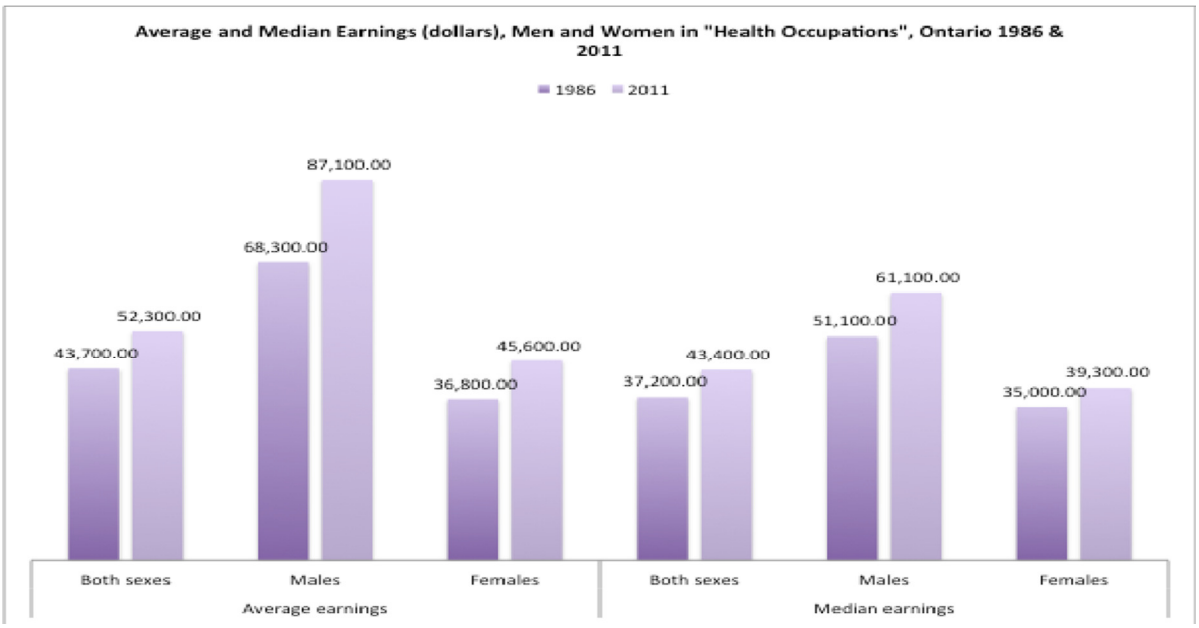


Figure 1: Female-to-Male Earnings Ratio, Health Occupations, Ontario 1986 & 2011.[231]

500. Figure 2 shows that a gap remains whether we look at average or median Health Occupations earnings:



230 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para. 65.

231 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para. 65..

Figure 2: Average and Median Earnings, Men and Women in Health Occupations, Ontario 1986 & 2011.[232]

501. Dr. Armstrong also testified:

> *There is significant segregation, which has changed only slowly over time in most occupational categories, combined with a continuing gender gap in wages. The historical segregation leaves significant traces in health care occupations especially, even though some of the distributions among women and men are changing. Given Ontario's human rights commitment to addressing discrimination in employment, the data prompts investigation into the specific case of midwifery."* [233]

502. Ms. Jodey Porter acknowledged in her testimony that at the time of midwifery regulation there was a great deal of gender disparity across all of the professions under the *Regulated Health Professions Act*, and lot of "gender tilting" among the health professions, acknowledging the significant occupational segregation at the time.[234] Porter said that:

> *so many of the professions are gender-tilted and really, our objective was to re-balance those professions, that more female registrants in medical schools, more male registrants in nursing, and still in all, a number of professions remain virtually all female. What we were focusing on really wasn't issues of gender for gender bias, but issues of competency, core competency, and what they could contribute to the system, and really that was -- and that's a huge piece, and that's what filter screen occupied our time.*[235]

503. The MOHLTC and its experts do not acknowledged the occupational segregation of midwifery and the resultant increased risk of devaluing the work of midwives. Nor did the MOHLTC experts acknowledge occupational segregation in their reports as a potential factor to explain midwifery compensation.

504. Associate Minister of Health Nancy Naylor seemed surprised to learn during her testimony that approximately 80% of the health care work force was female.[236]

C. The Connection between Sex/Gender, Work, Occupational Segregation and Lower and Unequal Pay in Health Care

505. Dr. Armstrong in her expert evidence has highlighted the close connection between gender and occupations noting that the higher the predominance of

---

232 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para. 66.

233 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para. 70.

234 Testimony of Jodey Porter, Transcript, February 21 2017, at pp. 208 – 209.

235 Testimony of Jodey Porter, Transcript, February 21 2017, at p. 213.

236 Testimony of Nancy Naylor, Transcript, November 3, 2016, at p. 50.

women in an occupation, the lower the pay. In these circumstances, it is very difficult to understand the MOHLTC defence in this case that the difference in pay is based on "occupational" status and not gender. Based on the sociological evidence which was the foundation of Ontario's Green Paper on Pay Equity and the two Pay Equity Hearings Tribunal decisions in the early 1990's *ONA v. Haldimand Norfolk* and *ONA v. Women's College Hospital* (which relied on Dr. Armstrong's opinions) – gender infuses the values and pay of women's and men's work.

506. That is why the *Pay Equity Act* provides in its Preamble that systemic gender discrimination exists in the compensation of female job classes in Ontario. In other words, there is a gender penalty women experience in monetary terms for being part of a predominantly female profession. Pay or human rights analyses must be proactively applied to identify and eliminate that penalty.

507. Dr. Armstrong acknowledged the stubbornness of the occupational segregation issue, and provided a rationale for its endurance:

In spite of some changes, the overall patterns of gender-based occupational segregation remain in Canada and are evident in Ontario."[237]

"Discrimination embedded in compensation systems and in market mechanisms helps explain this persistence. Indeed, the evidence showing the systemic market discrimination against women's work is the basis for Canadian human rights laws and for our international commitments to addressing sex discrimination and promoting equal pay for work of equal value. Such legislation is intended to ensure that women are not discriminated against for doing work traditionally done by women by pro-actively making visible and valuing their work. It recognizes that what is not made visible cannot be valued. " [238]

508. The government, in its background paper to the Closing the Gender Wage Gap Strategy, describes occupational segregation as: "horizontal segregation (across occupations) and vertical segregation (within the hierarchy of occupations)… It is based on social or cultural norms and beliefs that under-value women's work."[239] Dr. Kervin also highlighted this segregation can also in addition be sectoral.

509. Dr. John Kervin described occupational segregation, with respect to the major disadvantages faced by women, as "*the mother of all the problems that women face".*[240]

---

237 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para 7.

238 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para 10.

239 "Closing the Gender Wage Gap: A Background Paper", Ministry of Labour (October 2015), (Exhibit 148), at p. 35.

240 Testimony of John Kervin, Transcript, March 27, 2017, at p.63

510. Dr. Kervin has written on the subject of job gender and devaluation and noted:

"Gender composition - the proportion of women doing the work - is related to wage bias in occupations, organizations, and jobs… Gender-related wage bias is the difference between a job's wages and what it would be paid if it were filled with male employees, net of its [real] worth to the organization."[241]

511. Dr. Kervin stated that occupational segregation can be horizontal and vertical in the labour market, as well as sectoral.

512. It is clear from such government statements and the expert reports that a high level of gender occupational segregation within a market as is reflected in the case of physicians and midwifery is a key indicator of gender inequality.

513. When occupations are segregated by gender either currently or historically, there is a significantly increased tendency to devalue women's work, and therefore, there is greater tendency towards larger gender pay gaps. Men in their segregated occupations are in a stronger position to take advantage and benefit from this devaluation and women are less able to oppose and reverse such as devaluation.

514. Ontario's highly gendered health care labour market has evolved over time. In a system with long history of segregation and gendered lower pay for women on average, the systems which compensate and value work are resistant, even blind, to new systems of valuation that might challenge the status quo by uncovering the inequities built within.

515. Dr. Kervin states in his paper "Job Gender and Job Devaluation in Fifteen Organizations":

Research consistently finds that work largely performed by women is typically paid less than men's work, net of human capital and other factors affecting wages….This research confirms the well-established observation that gender bias (measured here as job devaluation) is related to the gender composition of a job. The more women in the job relative to men, the lower the wages relative to what an all-male job would be paid"[242]

516. Research on occupational segregation, much of which has been conducted by Dr. Armstrong and the Ontario government has been extensive over the past three decades and has consistently found a significant net wage penalty associated with female-dominated occupations. It has found that both men and women tend to give higher value to the work performed by men; once an occupation is considered to be "female", then an institutional type inertia sets in

---

241 Testimony of John Kervin, Transcript, March 27, 2017,at pp. 65 - 66.

242 Kervin, John, and S. Reid "Job Gender and Job Devaluation in Fifteen Organizations", (Exhibit 279, Tab 15) at p. 6.

that keeps that occupation locked in this segregated pattern, making it more and more difficult to change. The government has cited 2014 research that showed "gender differences in occupation accounted for 21% of the total hourly gender wage gap."[243]

517. That is, occupational segregation speaks to devaluation that takes place in a larger context, beyond any single employment establishment. It is systemic and requires attention at the systems level to prevent it and eliminate it if it is there.

518. Dr. Kervin provide a clear explanation of how occupational segregation affects compensation:

> *Societal and organizational stereotypes that devalue women and their work lead to sex segregation in occupations and jobs (Reskin and Bielby, 2005). Jobs filled mostly by women, or that involves tasks that are culturally defined as "women's work", are seen by managers as less demanding, requiring less skill, or having more desirable working conditions (Steinberg 1990). Employers thus pay these jobs less (England et al. 2005; Maume 1999). Both male and female incumbents in these female-dominated jobs are paid less than if the job was filled mostly by men. Thus, cultural beliefs and values attached to jobs' tasks or gender composition result in lower compensation (Barnett, Baron, and Stuart 2000). Empirical findings show support for both sets of explanations. Both individual attributes and preferences, and organizational and social culture explain how sex composition is related to compensation….*
>
> *Explanations based on social and organization culture and stereotypes involve managers' perceptions that jobs are "male" or "female" (or perhaps "mixed"). When a job is perceived to fall into one of these categories, stereotypical gender-related beliefs and values become salient and affect decisions about wages. Thus, managers' beliefs about what is "appropriate" compensation for women or for female-dominated jobs are triggered at the point where a job is perceived to be "women's work".*
>
> *We assume here that this perception is based on the proportion of women in the job (although it could also be based on the job's task content). These explanations implicitly predict that wage bias will occur only after the proportion of females in a job has reached a tipping point at which the job is perceived as women's work. Job devaluation and lower wages occur for all jobs past that point."*[244]

519. Dr. Armstrong concurs:

---

243 "Closing the Gender Wage Gap: A Background Paper", Ministry of Labour (October 2015), (Exhibit 148), at p. 35.

244 Kervin, John, and S. Reid "Job Gender and Job Devaluation in Fifteen Organizations", (Exhibit 279, Tab 15) at p. 4.

Systemic gender discrimination in compensation refers to overall patterns in the labour force that are at least in part attributable to ideas about women and men's work; ideas that attach lower worth to work done mainly by women, but gender discrimination is still also about discrimination based on sex. There is a system wide structure of disadvantage for those doing women's work and advantages for those doing men's work. [245]

D. Midwives and the Gendered Trifecta - A Uniquely Gendered Profession

520. As detail above in Part 2 and throughout this submission, midwifery is a uniquely gendered profession and the health care profession with the highest female predominance at 99.9%. They also are associated with women as their clients and with women's biological health care needs which together results in the "gendered trifecta" of disadvantage.

E. Gender Profile of Nurse Practitioners

521. There is no dispute amongst the parties that 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.[246]

F. Gender Profile of Physicians

1. Introduction

522. The Tribunal received in evidence a Chart prepared by the Canadian Institute for Health Information (CIHI) which sets out numbers and sex of physicians in Ontario and Canada, from 1978 – to 2014 broken down by All Physicians, Family Physicians and Obstetricians/Gynaecologists.[247] This Chart provides the most comprehensive information available to the Tribunal for those categories.

523. Appendix 5, The Overview Summary of Evidence by Chronological Eras from 1994, sets out at the start of each era the gender profile of the family physicians and all physicians in Ontario.

2. All Ontario Physicians

---

245 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para 72.

246 Canadian Nurses Association, "2010 Workforce Profile of Nurse Practitioners in Canada" and Health Professions Database. November 2012. Affidavit of Theresa Agnew, (Exhibit 129, Tab 5)

247 "CIHI physician gender distribution charts (1978- 2014)", Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 21).

524. According to the CIHI data, all Ontario physicians were 88.1% male in 1978, 75.3% male in 1993 and 62.4% male as of 2014.[248]

3. Ontario Family Physicians

525. Family physicians in Canada have ranged from originally being exclusively male to approximately 86% male in 1978 to about 71% male in 1993 to approximately 60% male in 2010.[249]

4. CHC Physicians

526. The AOM does not dispute that CHC physicians were majority female by 2004 as set out in documents appended to Ms. Scarth's affidavit.[250]

527. While there are increasing numbers of women physicians generally and there is evidence that women physicians have chosen to work in Community Health Centres in greater numbers than other areas of medical profession, the physician profession is still male-dominated and continues to exist in a model originally established by and for men as Dr. Armstrong and Dr. Bourgeault and Mr. Durber conclude in their reports

5. Gender Profile of Physician Institutions

528. The numeric gender composition of the profession, albeit improving, still is not equal. However, in considering both the maleness and the dominance of men in Ontario's health care system, not only does numeric gender composition need to be considered, but the dominance in the leadership, decision making and influencing organizations must also be considered. In the areas of regulation, academia and physician representation, men continue to dominate.

6. The Ontario Medical Association

529. The male predominance of medicine as a field of work in Ontario is particularly highlighted in the decision-making structure of its representative organization, the Ontario Medical Association, which has few women in leadership positions despite their increasing numbers.

---

248 "CIHI physician gender distribution charts (1978- 2014)", Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 21).

249 "CIHI physician gender distribution charts (1978- 2014)", Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 21).

250 Affidavit of Fredrika Scarth, (Exhibit 187), at para. 91.

530. The OMA is the entity the Ministry bargains with for Ontario physicians including CHC physicians. 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.[251] At the same time the CIHI Chart shows that 63.2% of Ontario physicians were men in 2013.[252]

7. The College of Physicians and Surgeons of Ontario

531. This male predominance in physicians' institutions is also reflected in the leadership of the College of Physicians and Surgeons in Ontario which is almost exclusively male.[253]

8. Medical Academic Leadership \Gender Profile of Physicians and their Representatives and Related Institutions

532. While Dr. Graves testified about progress in engendering medical academic leadership[254] and CHC physicians gave anecdotal testimony about some of their academic mentors who were women, the data shows that medicine academic leadership remains highly male.[255]

533. Dr. Graves testified to the composition of medical students and family medicine residents at the schools where Dr. Graves has taught. Tellingly, she was not able to state that there was equal representation of men and women in these schools in the past, or even now in 2017, but rather "approaching approximately 50 percent female" and "getting close to that 50 percent mark."[256] This is despite the fact that women have been entering medical schools in equal numbers to men since back in the early 1990s.

---

251 See Chart OMA Leadership Gender Breakdown Source: Issues of the Ontario Medical Review. – Affidavit of Theresa Agnew, (Exhibit 129, Tab 52)

252 "CIHI physician gender distribution charts (1978- 2014)", Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 21).

253 "CPSO Leadership Chart", Created by AOM", MOHLTC Expert Witness Documents, (Exhibit 279, Tab 96).

254 Refer to Testimony of Lisa Graves, Transcript, March 22, 2017; Testimony of Susan Woolhouse, Transcript, November 9, 2016; Testimony of MaryRose MacDonald, Transcript, November 9, 2016; Testimony of Nicole Nitti, Transcript, November 10, 2016; Testimony of Tara Kiran, Transcript, November 10, 2016

255 "CPSO Leadership Chart", Created by AOM", MOHLTC Expert Witness Documents, (Exhibit 279, Tab 96).

256 Testimony of Lisa Graves, Transcript, March 22, 2017, at pp. 47 – 48.

534. Dr. Johnson testified to the difference between equal numeric representation of men and women in a profession, and circumstances where men are overrepresented in those parts of the profession that are most highly paid, and overrepresented in leadership and decision-making positions. Dr. Johnson agreed that these are different circumstances than just consideration of numeric gender composition, which then could lead one to different conclusions about maleness or femaleness of a profession.[257]

535. Dr. Pat Armstrong stated in her expert report:

> *"men remain the most powerful teachers and supervisors in medicine, shaping the culture, values and evaluation of medicine. Men also dominate the associations that bargain wages and benefits for doctors. This historical and continuing male dominance continues to shape the evaluation and pay of physicians and makes physicians appropriate comparators for the purposes of assessing inequities between jobs traditionally associated with men and those traditionally associated with women."*[258]

536. The above-noted medical organizations have immense control over not only the profession of medicine but over other professions (for example, controlling access to midwives' hospital privileges) and the health care system (for example, influencing MOHLTC decisions regarding laws and regulations that govern that system).

537. Dr. Lisa Graves testified that the numbers of chairs and deans who are women at medical schools are low in relation to the numbers of women in medicine. Dr. Graves gave as an example: "In 2010, when I was the Associate Dean UME at NOSM, of the six Ontario medical schools, 2, or 33 percent of the associated undergraduate deans in Ontario were women."

538. Dr. Graves attributed this male dominance to the time it takes a physician to move through their career into leadership positions; given the suppression of women from medicine until the 1980's, this male domination of medical leadership positions continues today:

> *"We've got where we're at the point now where, you know, we are starting to not be -- not be in the minority. I don't think that we're there yet, but certainly because we don't match exactly, but when I look at the people I grew up with, the people who are my -- who are my classmates, who are my residency mates, who are my peers, I'm starting to see more and more of them sitting around the same sorts of leadership tables that I'm involved in and starting to see some of that change but, no, we're not there yet.*[259]

---

257 Testimony of Candace Johnson, Transcript, March 23, 2017, at pp. 32 - 33.

258 "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B) at para. 18.

259 Testimony of Lisa Graves, Transcript, Mach 22, 2017, at p. 48.

539. This explanation does not fully explain the dearth of women in leadership positions in medicine. In 2010, the Report to the House of Commons on the Status of Women (women in non-traditional careers) called out academic medicine for its male dominance in this field:

"Academic medicine is still wasting a great deal of the intellectual capital of its faculty women: many choose to "opt out" rather than navigate what is described as the chilly climate. The climate shift is occurring at different rates in different fields of medicine. To navigate it as individuals, each physician has had to face the systemic reasons why women do not advance at the same rate as men. Leadership gaps have still been demonstrated, despite systematic efforts at promotion, which has improved by over 60% in the last 10 years in Canada. The AFMC (Association of Faculties of Medicine in Canada) keep data that shows that within Universities, women comprise only18% of full professors of medicine and within hospitals, they comprise only 13% of department chairs. And while leadership of provincial and national medical organizations has shown increases, gaps remain."

540. Dr. Bourgeault is involved in ongoing research of the gendered experience of women in medicine and other health professions. Based on some of this early work, she testified that:

.. it's very clear that women have unique experiences within medicine, starting in access to medicine, going through medical school, negotiating residencies, and their experience as new registrants or new certificants, and then all the way through the system... Academic medicine intersects two professions of academia and the medical profession, both of which again are male dominant, but the hierarchy and the particular gendered hierarchy within the profession and within the academic arm of the profession is striking.[260]

541. The reasons for a lack of women in these leadership roles can also be a symptom of systemic gender discrimination within medicine as well. Female physicians can experience barriers to leadership such as work-life balance needs related to gender roles (childrearing and elder care), gender bias, or sexual harassment.

542. Drs. Palepu and Herbert articulated some of these barriers in an article in the Canadian Medical Association Journal:

Experiences of gender bias and sexual harassment are also downplayed, for a number of reasons. Harassment and discrimination emphasize one's position on the periphery of a group; few of us want to be the one to complain (which calls attention to this disadvantage) or to be seen as overreacting (an interpretation that trivializes women's experience.) Often, we think that defensive action will

[260] Testimony of Ivy Bourgeault, Transcript, March 21, 2017, at p. 41 – 42.

compromise the position we have… It requires courage as well as mental and moral energy to deal effectively with sexual harassment, which, unfortunately, remains prevalent in medical schools as well as in academic medicine…

A national survey conducted in the United States found that 77% of women faculty experienced gender-based discrimination and harassment during their professional careers. These included behaviours, actions and policies that adversely affected work by resulting in disparate treatment according to gender or by creating an intimidating environment....

One qualitative study involving 34 department chairs in academic medicine found that barriers to women's advancement included manifestations of sexism in the professional environment and a lack of effective mentors. The situation is not different in Canada where a recent report examining the gender gap in the distribution of Canada Research Chairs found that only 21% of the Tier 2 posts went to women despite the fact that women comprise 33% of the assistant and associate professors eligible for the award. [261]

543. Dr. Bourgeault testified in her report to the culture that exists in medicine that creates barriers for female physicians:

With respect to medicine, we have witnessed over time an evolution of "keeping women out of medicine" to "making it uncomfortable to be in medicine". There exists for many women within medicine a 'chilly' gendered climate which Collins describes as: "indigenously produced organizational cultures, informal relations surrounding work, which can result in a situation uncomfortable for women". The research on gender differences in the practice of medicine, for example, reveals that even though women increasingly enter the field of medicine, they are segregated into less-paid and less lucrative positions, such as family practice or obstetrics. Additionally, within medicine there exists a culture of unreported or under-reported sexual harassment and a lack of female role models.... While there is some evidence that women could bring a change to the practice of medicine, the underrepresentation of women in high status medical specialties and at the top of the occupational hierarchy, creates barriers for achieving actual change in medical practice. Consequentially, medicine is still very much a male dominated profession in spite of the recent and rapid expansion of a number of women into its ranks.[262]

---

[261] A. Palepu and C. Herbert, "Medical Women in Academia: The Silence We Keep", CMAJ, October 2002, 167(8), Index – Documents Put To Lisa Graves (Exhibit 273, Tab 13).

[262] "Expert Report of Dr. Ivy Bourgeault, March 30, 2015," (Exhibit 265, Tab B). at para. 47.

544. The end result of these barriers to female physicians is a deep and entrenched dominance of men in leadership positions within medicine. This has had and continues to have profound effects on the predominantly female workforce in Ontario's health care system.

PART 19: ONTARIO HEALTH CARE AND MATERNAL AND NEW BORN CARE SYSTEM

1. Introduction

545. 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.

2. Overarching Health Promoting, Reform and Care Mandate and Action Plans of MOHLTC

546. The *Excellent Care for All Act*, (ECFAA) 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".[263]

547. These objectives are found in the Patient's First: Action Plan for Health Care and the Government's policy, "Transforming Ontario's Health Care System, Vision and Guiding Principles, which 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.[264]

548. This is frequently referred to as the principle - Right Care, Right Time and Right Provider and Place.

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

549. The Government has stated that it seeks to have its compensation and funding policies reward those who contribute to and serve its primary health care reform

263 *Excellent Care for All Act*, (Exhibit 154).

264 Patients First: Action Plan for Health Care (Toronto: Ministry of Health and Long Term Care, 2015), Affidavit of Nancy Naylor (Exhibit 146, Tab B).

objectives.[265] 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.

550. 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.

551. 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 13.

552. 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.

553. The following Ministry actions would facilitate the equitable integration and compensation of midwives: a) improving integration of midwives into hospitals (facilitate access to privileges and end restrictions to scope of practice that are not medically necessary); b) promoting out-of-hospital birth (home, clinic, birth centre); and c) 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 20: Inequitable Relationship of Midwifery Excellent Maternal Care Outcomes to Compensation

A. Gendered Differential in Rewarding Excellent Outcomes

554. There has been a long and consistent history of midwives supporting the values and objectives of the MOHLTC, and providing strong clinical outcomes to clients. There has been an equally long and consistent history of the MOHLTC failing to link those outcomes to compensation.

555. The MOHLTC also has a long history since 2004 of rewarding family physicians for doing work they should already be doing as primary care providers. This is another example of the differential and discriminatory treatment towards midwives. The following exchange with Sue Davey encapsulates the issue:

Q. …as a precious resource, as I understand it then from the Ministry's compensation strategy, they [midwives] weren't more valuable because they were a precious resource. They were cost-effective. They had very high

265 *Excellent Care for All Act*, (Exhibit 154).

consumer satisfaction. They met your primary care reform objectives. They agreed to be managed. All of these things made them, in fact, a poster person for health care reform. Wouldn't you agree?

A. Yes, I think so, and I think the Ministers always, no matter what party they were from actually, always acknowledged the value of the midwifery program and midwives. That's right.

Q. But I guess the problem, Ms. Davey, is that, and I know my client expressed this, continually acknowledging the value without paying people appropriately wears a little thin."[266]

556. Ms. Davey's testimony illustrates this different treatment towards the male dominated physician group:

Q. Just so I can understand this: The midwives, when they are regulated, agree to, if I could phrase it, "get with the program" and have a community-based managed system where the government controls where courses of care are.

A. That's correct.

Q. All right. And at this point, you can't get doctors to do that, back in '94. You still have a fee-for-service system and you're unable at the Ministry to control where doctors go.

A. Correct.

Q. All right. And you're not prepared to put controls on doctors.

A. I think that progressively over time, physicians have been encouraged to practice in different ways, but it's not a managed program and I think the Ministry learned that it's not an ideal way to provide services to your population.

Q. You mean fee for service?

A. Yes. Well, yes, and it's more effective to provide services through a program like the midwifery program.

Q. Right. So the doctors, because they've managed to have a fee-for-service program, end up having to be compensated more to actually provide health care in the areas that the province needs it.

A. Yes.

Q. And they also need to be compensated more to deliver preventative health care because, left on their own, they wouldn't do it. Is that it?

---

[266] Testimony of Sue Davey, Transcript, November 1, 2016, at pp. 56 - 57.

A. Left on their own, the evidence was showing that they weren't doing it.

Q. … And yet the people who are doing it, have great outcomes, they go to the areas in which they're needed, the Ministry turns around and says to them, "Well, we don't have to pay you because you're already doing what we want."

A. The midwifery program and the CHC program are managed programs, and that's correct, so the funding goes to an organization to provide the services to the community.[267]

557. Numerous internal MOHLTC briefing notes refer to or detail positive midwifery outcomes. The positive outcomes of midwifery continue to be recognized by the MOHLTC. Ms. Scarth testified:

…there was a commitment to continue to grow the program, and I would say that that commitment had to do with the government's sense, the government's understanding of the value of the services, the value that it provides to women, because it's a very good care experience for women. We know that. It's high quality care, and I don't feel I can testify to it being cost savings in relation to other forms of maternity care, but I can say that as a program manager, I felt it was providing very good value… I am agreeing with you that midwifery care is very good value to our system in the sense that it's high quality, it's effective, it provides women with choice of birth place and birth provider, and women experience -- the client experience of care is very positive."[268]

B. Midwives Meet MOHLTC Policy Objectives and Support MOHLTC values

558. From prior to midwifery regulation, midwives have always supported MOHLTC values and objectives. At the time of regulation, midwives supported the concept of midwifery as a program managed by the MOHLTC, including the following elements inherent in a managed program:

(a) provide accountability and protect the model of midwifery care;

(b) ensure the responsible distribution of funding and services;

(c) a closed funding model, subject to the Ministry's budgetary approvals;

(d) financial and statistical reporting to the Ministry;

(e) funding structured to ensure that the supply of midwives is distributed to midwife practice groups across the province in direct response to the demand in the population.

---

267 Testimony of Sue Davey, Transcript, November 1, 2016, at pp. 41- 43.

268 Testimony of Fredrika Scarth, Transcript, December 9, 2016, at pp. 128 – 134.

559. When former AOM President Carol Cameron was asked if the AOM wanted to support this accountable model, she responded: *"We helped create it.``*[269]

560. Davey wrote a briefing note detailing the benefits of the midwifery model of care as it pertains to the government agenda:

> *Q. Midwifery model of care exemplifies key aspects of the government's transformation agenda: 24-hour on-call care, team practice, community-based care, reduced dependency on hospitals, cost-effective services and client-centred care. AOM is advocating promotion of midwifery as a good example of transformation success." I think I referred to this earlier as midwifery being the poster person for the government's agenda.*
>
> *A. Which is what we were reminding them of, yes.*[270]

561. The 2002 internal MOHLTC memo, "Primary Care Reform in Ontario: Current Status and Future Direction", laid out four primary care reform goals:

(a) Improve access to primary healthcare;

(b) Improve the quality and continuity of primary healthcare;

(c) Increase patient and provider satisfaction with the healthcare system; and

(d) Increase the cost-effectiveness of healthcare services "[271]

562. Ms. Davey agreed that midwifery did relate to these priorities by "providing greater emphasis on health promotion, disease and injury prevention…Also, care to be delivered by the most appropriate level of provider, again, and access to health care services 24 hours a day…certainly we did try to situate midwifery as part of primary health care reform".[272]

563. Former AOM President Bridget Lynch also spoke to the sense of alignment between midwifery and MOHLTC objectives, even during the challenging period of devolution of health care services:

> *So it was, I think, very reassuring for us at the AOM to see that we were moving into an alignment, some kind of alignment with the Ministry, which was essentially a commitment to support the midwifery model of care, to continue to*

---

269 Testimony of Carol Cameron, Transcript, September 22, 2016, at pp. 70 – 72.

270 Testimony of Sue Davey, Transcript, November 1, 2016, at p. 115.

271 "Primary Care Reform in Ontario: Current Status and Future Direction: MOH Internal Memo", Government Documents to put to Sue Davey, Volume 1 (Exhibit 142, Tab 46), at p. 1.

272 Testimony of Sue Davey, Transcript, November 2, 2016, at p. 17.

support it, and to uphold the Framework Agreement as we moved forward into devolution.[273]

564. A 2004 Toronto Star article outlined the MOHLTC goals in their negotiations with the OMA. It said: "The outcome is crucial to meeting the government's goals of eliminating doctor shortages, reforming primary care and reducing wait times – all while holding down total spending on health care."[274]

565. Former AOM President Elana Johnson testified that midwives had a role to play it the achievement of these goals: a) it was evident that that midwives would be a solution to eliminate the doctor shortage b) midwives were a part of reforming primary care

566. However, Johnson conceded that midwives would have less of a role to play in reducing wait times: "In fairness, the wait times there would be probably not talking about maternity care because babies don't wait".[275]

567. In summer 2010, the MOHLTC articulated to the Courtyard Group consultants some MOHLTC policy objectives (formal and informal), in line with the government's Patients First Action Plan, to be considered in the midwifery compensation evaluation exercise. The Courtyard report produced a table that mapped those objectives against the midwifery compensation model to determine how they aligned.[276]

Policy Objective	**Alignment of Compensation Model**
Reduce/minimize unnecessary interventions	Course of care funding structure does not reward midwives based on the number/volume of interventions provided for each client
Provide care close to home	Model of practice allows client to choose the location of her delivery (e.g. home or local hospital)
Ensure access for individuals in rural and/or remote areas	Supplements and incentives are provided for midwives practicing in remote/rural areas

273 Testimony of Bridget Lynch, Transcript, September 22, 2016, at p. 194.

274 "McGuinty facing tough decisions, Toronto Star Article, re: Liberal government upcoming challenges, (September 8, 2004)", (Exhibit 85, Tab 16).

275 Testimony of Elana Johnson, Transcript, October 5, 2016, at p. 251.

276 "Report by Courtyard Group for MOH re Compensation Review of Midwifery (September, 2010)", Affidavit of Katrina Kilroy, (Exhibit 91, Tab 40), at p. 19.

Optimize the use of health human resources	Modifications to scope of practice have enabled midwives to assume full responsibility for primary maternity care. This improve patients' access to the 'right' provider at the 'right' time
Recruit and retain qualified health human resources	Retention incentives have been put in place to ensure senior midwives continue to practice
Ensure access to 24 by 7 care	Course of care fees require midwives to be on-call for clients on a 24 by 7 basis

568. The aggregate clinical outcomes of midwifery are collected, monitored and evaluated by the MOHLTC, through BORN Ontario, to an extent that is rare in Ontario's health care system. Midwives have supported this, understanding the important link between data and quality care.

569. The Courtyard report acknowledged this strong link between data, outcomes and the requirement for midwives to provide data in order to be compensated:

> *In 2004 the Ministry defined a set of outcome and process related data elements that would enable the monitoring of health outcomes associated with the delivery of midwifery maternity care in Ontario. The dataset includes elements related to the demographics and health status of clients, the results of tests prescribed by best practice standards, as well as characteristics of the antepartum, intrapartum and postpartum care provided…Periodic adjustments can be made to this data set to influence the work performed by Midwives. For example, data elements related to H1N1 screening have been implemented to ensure Midwives explicitly assess the potential existence of H1N1 infections. Compared to other professions, the direct linkage between compensation and adherence to practice guidelines is quite strong in Midwifery."*[277]

570. Ms. Scarth testified to the most recent objectives of the midwifery program:

> *I would agree that those are good outcomes and that that kind of positive client satisfaction is a good outcome that we would want to support, that we think, you know, the midwifery program provides a very good service to women which is why one of the objectives of the program is to sustain and grow the provision of safe and effective and high quality maternity care to women.*[278]

C. MOHLTC did not take the cost-savings of midwifery care into account

---

277 "Report by Courtyard Group for MOH re Compensation Review of Midwifery (September, 2010)", Affidavit of Katrina Kilroy, (Exhibit 91, Tab 40), at p. 20.

278 Testimony of Fredrika Scarth, Transcript, December 8, 2016, at p. 208.

571. MOHLTC data showed that the costs per course of midwifery care compared to direct case cost at ministry-monitored hospitals indicated that home births saved the system from about $800 to $1,400 per birth; and that the costs for midwife-attended births in hospitals is $3,500 to $4,000 while the range for family physician-attended births is $4,200 to $5,600 (with respect to the family physician-attended births, taking into account the nursing costs and other ancillary costs). A specialist-attended C-section with a healthy newborn costs $5,700.[279] Ms. Davey agreed that the MOHLTC "definitely" had an interest in trying to avoid unnecessary C-section.

572. The approach by the MOHLTC to consider cost-savings in compensation setting is another example of the MOHLTC's different and discriminatory treatment of physicians and midwives. At times the government has publicly justified compensation increases to physicians by stating that, in return, the MOHLTC would receive system cost reductions from the physicians. However, Ms. Stadelbauer testified she has not seen the Ministry take into account the cost savings that midwives generate in the system in terms of saving the hospital costs, other kinds of health costs, etc., into account as a credit in relation to midwifery compensation.[280] This different approach was highlighted by the testimony of Ms. Farrell:

Q. The question was whether or not you took into consideration in addressing the midwives' income whether they saved the system money?

A. I think that argument is certainly something that's taken into consideration when we're looking at increases, salary increases or when we're talking about salary increases. I just have to be clear that when I was in the Primary Health Care Branch working on this particular portfolio, the entire time I was there, it was a time of salary constraint, so it was less about increases and more living within the constraint and constraint environment.

Q. And one of the things that you said actually in your testimony this morning which was talking about how lucrative the Family Health Networks were and why the doctors wanted to get into them now?

A. Mm-hmm.[281]

573. Ms. Pinkney provided some of the government's rationale for this:

---

279 Testimony of Sue Davey, Transcript, November 2, 2016, at p. 26.

280 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, at p. 40.

281 Testimony of Melissa Farrell, Transcript, December 2, 2016, at p. 238.

Q. Was there any thought given to whether or not the midwives could have been credited with these savings in terms of increasing their compensation?

A. No. There is not direct costs that, when you start looking at lower C-section rates, less interventions, it's not that money is or it's not that money is freed up and made available as a result of not having to undertake a Cesarean section or a readmission to hospital. There is not a specific amount of money that then you can take out of a hospital budget as an example".[282]

574. That is, MOHLTC has not considered the cost savings of midwives in the compensation because they there are no direct cost savings that they can apply elsewhere, unlike a budget line like the OHIP budget. In other words, unlike they have done for physicians, the MOHLTC has set up a system that is unable to recognize and reward cost savings, and therefore, are unwilling to provide midwives with that credit for their cost savings to the system. This differential approach and system has penalized the compensation of midwives.

D. Midwives were not rewarded for positive outcomes

575. A program evaluation of the Ontario midwifery program was undertaken in 2002. The midwives were told that a compensation increase could not be contemplated until this review was completed and showed that midwifery provided a good service.[283] The Ministry expected positive clinical results from Ontario midwives, based on their research of international comparators.[284]

576. The results of the 2002 program evaluation were very positive, and in line with the MOHLTC expectations.[285] [286] Sue Davey's affidavit gives a comprehensive summary of the very positive findings of the program evaluation "*and revealed that the OMP was achieving its objectives. Some of the draft findings included the following:*

In summary, the Midwifery Program has achieved remarkable progress towards meeting its business objectives in the nine years of the program's existence…

The evidence showed impressive clinical results for midwifery obstetrical care, based on 2002 Midwifery Program data compared to 2001-02 data for low risk obstetrical patients under physician care in Ontario and other benchmark studies:

1. Midwifery care in Ontario results in a substantially higher rate of breast-feeding both initially and at 6 weeks, than found for other groups, including for other

---

282 Testimony of Laura Pinkney, Transcript, November 8, 2016, at p. 159.

283 Testimony of Remi Ejiwunmi, Transcript, September 28, 2016, at p. 48.

284 Testimony of Sue Davey, Transcript, November 1, 2016, at p.46.

285 Testimony of Sue Davey, Transcript, November 1, 2016, at p.46.

286 Testimony of Sue Davey, Transcript, October 21, 2016, at p.46.

Ontario infants. Breast-feeding has been shown to improve many long-term health outcomes, such as improved immunity.

2. Midwifery care in Ontario results in a lower c-section rate comparable to ministry expectations for best practices and lower than the rate observed for the Ontario low risk cohort under physician care.

3. Midwifery care in Ontario results in a lower rate of forceps and vacuum extraction deliveries than the rate observed for the Ontario low risk cohort under physician care.

4. Midwifery care results in less damage to the perineum. In particular there was a substantially lower rate of episiotomies for women under midwifery care, than for the Ontario low risk cohort under physician care. 46

5. Evaluation results of home and hospital midwifery clinical outcomes indicate that the planned home setting poses no additional risk to mother or infant.

6. Midwifery care in Ontario does not increase the risk of fetal or neonatal death in comparison to the low risk cohort under the care of physicians.

7. Midwifery care results in a significantly higher incidence of maternal and infant early hospital discharge following midwife-attended birth than for the low risk cohort under the care of physicians.

8. Hospital re-admission rates are significantly lower than the overall rate of hospital re-admission for the low risk cohort under physician care.[287]

577. Ms. Ejiwunmi, former AOM President, summarized the results in her testimony:

those results were very positive. They provided that midwifery was in alignment with government priorities, that the clinical outcomes that midwifery provided were excellent, that there was an opportunity for cost savings because when compared to physician services, midwifery services were cost efficient because there were lower rates of readmission, higher rates of breastfeeding, lower rates of intervention, clinical intervention, that from a patient satisfaction standpoint, there was a 98 percent satisfaction rating. So by all measures, midwifery was providing excellent service to the women of Ontario and their babies.[288]

578. There were other measures of the success of midwifery beyond clinical results. The most appropriate level of provider was another theme of health policy; the MOHLTC was trying to find the most appropriate provider for the health care that

---

287 "Emails re: Midwifery Program Evaluation Working Group meetings with attachments, dated April 23, 2003", Affidavit of Sue Davey, (Exhibit 135, Tab 140), at para. 135.

288 Testimony of Remi Ejiwunmi, Transcript, September 28, 2016, at pp. 47- 48.

was being provided.[289] Ms. Davey testified that they expected midwifery would also positively contribute to this policy goal:

"The midwifery program assumes that the most appropriate level of care provider for normal pregnancy leads to low-intervention care and, therefore, lower cost care. Midwives and family physicians are the most appropriate level of care provider for normal pregnancy. Obstetricians are the most appropriate level of care provider for high-risk pregnancies and normal pregnancies that become complicated in the course of labour and delivery. The midwifery program assumes that health human resource planning would support increased access to the...appropriate level of care provider."[290]

Ms. Pinkney testified that the very excellent outcomes of midwives were reflected in briefing notes going into the 2008 negotiations. These outcomes were leveraged by the MOHLTC in its efforts to increase access of women to midwifery services by seeking to expand the program.[291]

579. However, the MOHLTC's understanding of the positive contributions of midwives was not considered in determining the compensation of midwives.[292] Despite the positive outcomes since prior to midwifery regulation, the MOHLTC first acknowledged that positive outcomes could be used in compensation setting was in 2011.[293] The MOHLTC proposed an increase that was tied to specific clinical outcomes; this increase was not guaranteed to every midwife, but would require individual midwives to show the outcomes for their clients, according to Ms. Pinkney: "So it may have varied amongst midwives… because it's specific to outcomes for individuals, and so it's being tracked that way as opposed to statements that say, you know, the outcomes appear to be good."[294]

Q. So we know with the midwives that they're already getting these outcomes. They're already doing what they're supposed to be doing. They've gotten with the program. They don't need to have all these specific things. They do all this data. All that's been clear for years, and you're telling me that this 2011 amount, you were actually contemplating having them do more detailed things, tracking it in order for them to get this 3 percent?...And you could imagine how, given that the midwives had had these good outcomes for years and not been compensated, they actually might have found that insulting?

---

289 Testimony of Sue Davey, Transcript, October 21, 2016, at p. 124.

290 Testimony of Sue Davey, Transcript, October 21, 2016, at p.124; "Midwifery Funding (For Internal Use Only) Final: March 21, 1996, prepared by Bonnie Heath, Co-Ordinator, OMP, Community Health Branch", Government Documents – Sue Davey, (Exhibit 142, Tab 19), at p. 13.

291 Testimony of Laura Pinkney, Transcript, November 4, 2016, at pp. 200-202.

292 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p. 202.

293 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p. 202-203.

294 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p. 203.

A. I think the Ministry was looking at it as a way to build in to the compensation, to have it tied to those, so you're actually saying these are a recognition more so than an insult, as you're putting it.[295]

580. However, despite these consistent positive outcomes, the MOHLTC has failed to provide any type of recognition to midwives for their strong contributions to client care and the health care system. Former AOM President Lynch spoke to the early frustrations of midwives with the MOHLTC's lack of attention to their compensation:

We had poured an intense amount of "in good faith" working with the Ministry to, in fact, develop a funding mechanism that would support the model of midwifery in this province as well as the autonomy, which the government agreed when we first legislated midwifery. They agreed to, they supported, they initiated, they brought to this province. We often found ourselves in the negotiations protecting that very model on behalf of the government, and it's a model that the government extols the virtues of nationally and internationally, and yet it's ironic that the AOM I think found ourselves in the place of protecting the autonomy and the model that the province, in fact, has every right to be very proud of.

So having finished that incredibly stressful process in good faith, when we went to the government to talk about COLA, which was included in our framework document, which was part of the process that was agreed by the government and the AOM in our very framework document, and we went to them to discuss COLA, there was no answer for three letters. It was only when we threatened to not sign the new budget that there was a response from the CHB and the response was simply, "No, we're not giving you COLA…. the rationale given was that we're supporting the growth of the Ontario midwifery program…[296]

E. Physicians Rewarded and Incented

581. While midwives were being denied compensation increases, implementation of compensation reviews, and consideration of whether there were equity issues in midwifery compensation, physicians were being rewarded and incented by the MOHLTC for various activities and behaviours. Ms. Farrell was quite forthcoming about the incentives provided to physicians, and how they were necessary to have physicians provide care that would meet MOHLTC objectives:

Q. But you'll agree with me that, and maybe you know this now from the history of it, that initially, the doctors opposed being in these groups….

…A. Yes, they did.

---

295 Testimony of Laura Pinkney, Transcript, November 4, 2016, at pp. 206-207.

296 Testimony of Bridget Lynch, Transcript, September 22, 2016, at pp. 213-214.

Q. And then it took the government actually I'll describe it as throwing a fair amount of money at them to get them to get into the groups and to work with interprofessional providers.

A. It was part of change management and to shift the -- what they called the brain drain at the time. That was the headline, the brain drain. There was investments that were made in improving compensation for family doctors, yes.

Q. Right. And so they got a substantial amount of money and now it's considered really lucrative to do it.

A. They are the appealing models. They want to not just -- they don't want to work in a Family Health Organization or a Family Health Network, based on my experience working with primary care docs, they don't -- it's not just for money they want to work in that practice. It's because it's a better way of practising to work more interprofessionally.

Q. Well, they've come to that conclusion. They didn't have that conclusion originally, right? We've had -- seen documents about how some doctors didn't want to work with nurse practitioners, didn't necessarily want an interprofessional model, but over time, and I think we've seen they got paid $10,000 if they worked at a nurse practitioner, so over the period of time, now they like the model and they get a lot of money to do it.

A. They definitely like the model, yes.

Q. All right. And the incentives in a variety of things have allowed them to, in fact, increase -- I think we have a document somewhere about how much they were able to increase their pay over the period from the time the model started to now. There were pretty substantial increases in family physician salaries.

A. Yes.

Q. Right?

A. The shift from fee for service to working in a FHN or a FHO.

Q. All right. And they moved to a patient-centered or more focused model that was more consistent with the government's primary care reform strategy, right?

A. Correct.

Q. And one that looked at more prevention, et cetera.

A. Correct[297]

---

[297] Testimony of Melissa Farrell, Transcript, December 2, 2016, at pp. 239-241.

582. Other activities and behaviours that were rewarded include:

a. Nurse Practitioners Demonstration Project

583. Davey testified that in 2004 the OMA Physician Services Agreement included a "Nurse Practitioners Demonstration Project". Physicians were given an extra $10,000 for collaborating in the project.[298] Davey said*:*

the Ministry was interested in having nurse practitioners working with physician practices other than just with CHCs and was interested in promoting that. And so in order to get the physicians in those other payment arrangements, like the Family Health Organizations or the Family Health Networks on the community-sponsored contracts… In order to get them to participate, they provided an incentive to do so.[299]

b. Family physicians health promotion

584. Ms. Pinkney testified to the incentives provided to family physicians for basic primary care activities:

If you looked at referencing to the primary care groups, so that's the physician models, for those particular models where you had enrollments and you had bonus and incentive payments, the incentive payments were based on attaining certain levels. So as an example, from the time when I was there, if you had Pap smears for women within a certain age range…or mammographies for women within a certain age range, the percentage of your population, there were grids, so the more compliant your patient population were or the more screening that you were conducting for those patients, the higher the level of the incentive that was obtained.

Q. So it wasn't an outcome. It was -- you're saying that if you could persuade a patient to have a mammogram, you could get that bonus?

A. If you would follow up with patients within the recommended age brackets for things like mammography, or there were -- childhood immunizations were others, there were grids that, based on percentages, there were different dollar amounts.

Q. And these professionals couldn't just be counted upon to do that themselves and paid for. They had to have it done this way?

A. No, as part of primary care reform, there really was a movement undertaken to address changes to the funding parameters for family physicians, and that had been tied to less physicians choosing general practice or family practice, and

---

298 "2004 Physician Services Framework Agreement between MOHLTC and OMA", Joint Book of Final Agreements, (Exhibit 144, Tab 8), Appendix E, at p. 7.

299 Testimony of Sue Davey, Transcript, November 2, 2016, at p. 40.

having other opportunities where you're seeing them take on or go and become specialists. And so there was a point in time where access to a family physician was an identified issue in terms of patients not having access to family physicians. So a lot of what had occurred had been the creation of new models, and part of those models talked about enrolment, your having rosters of patients, so you and your group are responsible for care for those patients, and part of that initiative was also to recognize certain areas where the Ministry felt that there were focused -- focus needed to be placed on deliverables and those were built in as part of bonuses or incentive payments.[300]

585. Dr. David Price confirmed that:

the Ministry had a benchmark in what they wanted to get the family physicians to in terms of the negotiations, and it's how do you remunerate them to that level? And you can either do, and they talk about this all the time, you can either just give family docs an across the board increase or you can break it down and try to incentivize or encourage behaviours in a certain area, and that was one of the decisions was to try and look at quality improvement in terms of outcomes of immunization rates, those sort of things, mammogram rates, Pap test, whatever it was … it had the intended effect for sure of increasing our rates in those targeted areas. It did also remunerate the physicians more.[301]

c. Family physicians refer out pregnant women at 28 weeks

586. Dr. Graves testified to the problematic nature of this practice, which family physicians are not penalized for:

Q. I am just asking you with respect to continuity of care, which I understand is quite important to the family physician model, as I understand it, but we've had evidence that in the CHCs low-risk women are, as a matter of routine, referred out at 28 weeks, and come back after the birth, and is that a policy that you approve of? […]

A. Again, I can't comment on why the CHCs would do that. Certainly it would -- the best framework to put it in, if I were working in a CHC and I was advised of that policy, I would be working fairly aggressively to say is this really in the best interest of women and their families?"[302]

d. CHC incentives

587. Ms. Davey and Mr. Thornley testified to that the initial incentives to CHC physicians were complicated and difficult in that they were incenting those

---

300 Testimony of Laura Pinkney, Transcript, November 4, 2016, at pp. 204–206.

301 Testimony of David Price, Transcript, April 4, 2016, at pp. 158–160.

302 Testimony of Lisa Graves, Transcript, March 22, 2016, at pp. 95-97.

physicians to do work that the MOHLTC already expected CHC physicians would provide:

this was an ongoing process to try and come up with ways to establish a fair way to give CHCs incentives. So this changed year over year over year, and so where it ended up, I don't know. Where it was suggested we go was let's have adjustments for any kinds of extended hours of service, blocks of time for extended hours of service in CHCs…there was another complicating factor for this in that Community Health Centre physicians were paid as part of their salary to do preventive care, so it was hard to tease that out as being something extra that they were doing when it was already presumed to be part of what they were doing….So the things that were sector-wide were for those -- they were salary-linked adjustments for those kinds of services that you expected all CHC physicians to be doing anyway in relation to preventive care, and the ones that were funded through the CHC level, this is the difference that I'm -- between these two, the salary-linked versus the CHC level, the incentives to be funded through the CHC level were those things that were special to that CHC.[303]

Q. …Why would you pay the CHC physicians, let's just take the salary-linked adjustment, we I think have a letter that in that year, it was $4,660, to do things that were already in their job description?

A. Exactly, which is why the incentive program was so difficult, and in the end, was taken away from, was removed from consideration.

Q. Because, in fact, it didn't make sense to pay them for something they were already supposed to be doing.

A. Which was very complicating, which was the argument I was giving, yes.[304]

588. Mr. Thornley testified that the incentives provided to other family physicians exacerbated the compensation differences in the CHC sector, and that the Community Health Branch had to put an elaborate process in place to harmonize the physicians' compensation with the rest of the sector:

Q. Was this harmonization with this system of incentives, was that an attempt to change the way physicians -- CHC physicians were practising or to change the kinds of services they were offering?

A. Well, there is kind of two parts to that. So, as it relates to the other practice models, it was to make sure that the compensation package going to the physicians paid in other models was rewarding certain kinds of behaviours. So, the model that was in place earlier didn't have that and so they built that in as part of the overall … that the Ministry built that in. The primary care branch

303 Testimony of Sue Davey, Transcript, November 1, 2016, at p. 152-153.

304 Testimony of Sue Davey, Transcript, November 1, 2016, at p. 153.

wanted part of the physician compensation for primary care docs in the other models to be a function of demonstrating that they were doing these incentivized tasks. And so that became part of an overall compensation bundle. The challenge that created for the CHCs was we already had a problem dating from the late...late '90s, and we're now in years 2004, 2005, where this added layer of incented payments is exacerbating an already difficult situation because it's adding to the compensation of the other models and potentially creating a larger barrier.

So, we were making the arguments that our docs are already doing these things now. It's just good primary care and, therefore, they ought to get -- that gap ought to be smaller. And the answer we got essentially was, you know, show me. And so we had to, you know, put in place this fairly like elaborate process which was inconsistent with the culture and the working and behaviours of the people in the organization and convince them that we had to do this for two or three years in the hope that we would eventually end up back with a salary model."[305]

589. The MOHLTC paid physicians to do work that it was assumed midwives were doing:

You know, there was, for example, the incenting of CHC family physicians and physicians in general to do certain types of work that the Ministry wants or to give service in a particular way that would fit with the Ministry's transformation agenda. So, for example, to be community-based, to be on call, to be available to patients. They were being incented to do that work as physicians, and it was just assumed that midwives would do that work and I feel like that's gender-based, and I don't feel like there's any recognition of that in their affidavits.[306]

590. Ms. Farrell agreed with the following description of midwifery and CHC physicians within the MOHLTC's primary care strategy:[307] Midwives weren't required to be paid to be persuaded to be patient-centered, or to be involved in a managed program where the MOHLTC managed where they practised, how many courses of care they had; midwives were willing to align themselves with the MOHLTC in these when they were regulated. Physicians did not, with the exception of those doctors who worked in Community Health Centres. Those physicians were salaried and in a program that was consistent with the government's primary care strategy. Therefore, at the time of the regulation, the two entities that the government had in a primary care strategy were the salaried physicians in Community Health Centres were carrying out primary care reform, and the midwives in a managed program.

---

305 Testimony of David Thornley, Transcript, December 1, 2016, at pp. 79-80.

306 Testimony of Katrina Kilroy, Transcript, October 7, 2016, at p. 71.

307 Testimony of Melissa Farrell, Transcript, December 2, 2016, at pp. 241-242.

591. However, despite these similarities and that these two programs were key to primary care reform, only the CHC physicians were rewarded, and recognized, with compensation, for that contribution to primary care reform.

592. The MOHLTC provided these incentives with little evidence that they would achieve the policy objectives desired. Dr. Kiran testified about two different research studies she had conducted on the lack of effectiveness of incentive payments to physicians:

> *this incentive was introduced for family doctors in 2002 and family doctors could get the incentive if they saw a patient with diabetes and completed a comprehensive assessment.…And so what we found is that the introduction of this code led to minimal improvement of quality of diabetes care at the population and at the patient level. And our findings suggested that that was because physicians who provided highest quality care prior to the incentives were probably most likely to actually claim the incentive payments.…there was very low uptake. Seventy-five percent of physicians didn't even bill it, and those were the physicians who were less likely to do the comprehensive diabetes assessment.*[308]

> *"we looked at the impact of the preventive care bonuses, so the specific incentive payments for cervical, breast and colorectal cancer that were introduced around 2008 in Ontario for family doctors.... And one of the things that we found was that overall cervical and breast cancer screening rates, when you looked at them over time, there was actually very little change in the overall screening rate, you know, before versus after the incentive.*[309]

593. One unintended consequence of incenting physicians was it emboldened the physicians to believe that they could be incented by the MOHLTC to not engage in obstructing midwifery hospital privileges, as Ms. Davey testified to:

> *Q. And then on the next page or final page of the document it has "Confidential Advice to the Minister" and it states: "The Ministry has learned that specialist obstetricians, those generally responsible for approving midwife applications for hospital privileges, determining hospital budgets and local clinical protocols, may have been advised by a professional association to obtain Ministry compensation prior to enabling primary health care providers to repatriate the delivery of primary care maternity services." Can you tell us what that means?...*
>
> *A. Well, I think what it's saying is that we understand that the obstetricians are -- might have been advised that they should hold out for some funding before they agreed to granting privileges to midwives.*[310]

---

308 Testimony of Tara Kiran, Transcript, November 10, 2016, at p. 197.

309 Testimony of Tara Kiran, Transcript, November 10, 2016, at p. 199.

310 Testimony of Sue Davey, Transcript, November 2, 2016, at p.42.

F. The MOHLTC were well aware of the positive outcomes of midwifery

594. The MOHLTC has extensive data available to them within the health care system, which they use to formulate or move forward the priorities, according to Associate Deputy Minister Nancy Naylor:

we have a rich…array of data sources, but we are always looking at sector data. So, a few examples are always on our boardroom table…And we pay a fair bit of attention to the primary care statistics. So, we're always looking as a priority of the government to support primary care access, connection to primary care providers, and not just whether an Ontarian has a primary care provider but whether they have good access, same day, next day access if they are feeling ill, weekend access or after-hours access.[311]

595. Ms. Pinkney acknowledged, during her testimony, that there was positive acknowledgment by the MOHLTC for positive midwifery outcomes:

Q …at the bottom of the third page of that document… it says: "Is the program cost effective and is the Ministry getting high value for money? This can be a challenge for programs that do not have performance measures. In the absence of such, how does the program assess cost effectiveness and value for money?" And the respond was: "Yes, given the number of midwives who are entering the profession each year, and the increase in the number of clients served, and the number of FTEs involved in the program delivery, as well as program outcomes, the program remains cost effective and the Ministry is getting high value for the money." Do you agree with that assessment?

A. It would appear that they are indicating that the program is growing each year. We're able to recruit additional midwives to increase access and, as a result, it's considered to be a cost effective program. And that the Ministry is getting value for money.

Q. High value, right?

A. Yes. It's referencing -- this document says the Ministry is getting high value for the money. So, midwives are delivering the services that they are being funded to deliver.[312]

596. However, despite this knowledge, the MOHLTC did not act to ensure that midwives were appropriately valued for their work.

G. The MOHLTC's actions had a direct impact on midwives' sense of Worth

311 Testimony of Nancy Naylor, Transcript, November 3, 2016, at p. 13.

312 Testimony of Laura Pinkney, Transcript, November 8, 2016, at pp. 43-44.

597. Midwifery outcomes have consistently been as good as or better than physician outcomes on all measures since the inception of the program. Midwifery has been shown to be cost-effective and to align extremely well with MOHLTC objectives and values. However, there is no evidence that the MOHLTC has appropriately considered these outcomes in any compensation analysis.

598. Furthermore, the MOHLTC seems oblivious to how such treatment affects the dignity and self-worth of the midwives. Several midwives testified to this:

> *A. It's very difficult to feel proud about being a midwife. I find it deeply humiliating to have -- to pour my heart out in terms of caring for women the way we care for them as midwives. The government has been very clear that they recognize the value that midwives have provided to the health care system and that they appreciate the care that they provide to women. They recognize that our outcomes are better than physicians. We have less interventions. We're cost effective. Like, there are so many ways in which the Ministry has sort of showered us with praise, but the one way that would actually help us realize that we are valued, they have not. They have not increased our compensation. And it just makes it really hard to believe their words.*[313]"

> *"It was exhausting. It was demoralizing. It felt like we repetitively went to the table with members of both the Minister's staff and the OMP staff and were given rationale for why compensation reviews needed to be delayed, and at every point, we followed the rules, we abided by whatever the next thing was that needed to be accomplished before compensation could be addressed and every time we jumped through that hoop, we were right back where we started, and so it really did start to feel like we weren't sure what we were going to have to do to be able to achieve what we felt like was a fair and appropriate compensation for midwives, given the number of years that had passed with no adjustments.*[314]

> *"And I must say I was naive. I was shocked. I felt duped. I felt we had, you know, just crossed the Rubicon together and, you know, we were just left high and dry. It was, to be the leader of the organization at that point, it was devastating."*[315]

[313] Testimony of Maureen Silverman, Transcript, October 18, 2016, at p. 66.

[314] Testimony of Remi Ejiwunmi, Transcript, September 28, 2016, at p. 52

[315] Testimony of Bridget Lynch Transcript, September 22, 2016, at p. 215.

PART 21: ONGOING STEREOTYPES, BIASES, BARRIERS AND ANIMUS AGAINST MIDWIVES

A. Ongoing Stereotypes, Biases and Animus Against Midwives and Favoring Physicians

599. Each of the AOM midwifery witnesses testified to their experiences of encountering gendered myths prejudices, stereotypes as well as overt hostility in carrying out their work and providing empowering midwifery care to women and their families. The midwives experienced this behaviour group as dismissive and undermining and interfered with their ability to provide excellent care for women. These experiences of unequal gendered treatment and prejudice start pre-regulation and continue to this date. The experiences and treatment which are summarized below are not unique to Ontario.

600. The recent World Health Organization report, "Midwives Voices, Midwives Realities" which surveyed over 2,470 midwives in 93 countries also reported on these experiences of prejudice and unequal treatment being experienced in varying degrees and contexts in all countries. The report highlights the universal themes of gender discrimination and devaluing of the work midwives are subjected to “a critical and recurrent issue voiced though this exercise is that, because most midwives are women, what they experience is embedded in the context of gender inequality. Importantly this finding is universal…the participants expressed concern about a lack of understanding of what “midwifery” is, the devaluing of the midwifery profession combined with the increasing medicalization of birth, and the underlying weakness in midwifery education and regulation.”[316]

B. Pre-Regulation to 1993

601. There is extensive evidence of the myths, prejudices, and stereotypes which characterized midwifery and midwives up to the time of regulation set out in the Government's 1987 TFIMO report and in particular in the Report's Appendix 1 – The History of Midwifery in Canada. That history described how the highly developed birth culture in Canada based on midwifery was "gradually eclipsed by expanding medical control of childbirth." As "modern obstetrics" made a "clean sweep". "it was necessary to promote the view that traditional child birth was dirty and potentially dangerous." "In much of the country "birth was regarded as an event that was central to life of the community, intimately a part of women's culture – and midwifery was thus rarely a trade or profession in any sense that

316 “Midwives’ Voices Midwives’ Realities” Documents Put to Candace Johnson (Exhibit 275, Tab 2) pp. 1, 26-30.

was parallel to the professional ambitions of doctors." [317] Midwives were closely associated with the home and female neighbours helping one another.

602. See also Appendix 7 to this Submission, "History of Midwifery - Suppression and Re-Emergence of Female Predominant Profession. This history is also contained in Dr. Bourgeault's book, Push.

603. In 1865, the Ontario government eliminated the exemption under the *Medicine Act* which made it possible for midwives to practice midwifery without a license to practice medicine.[318] The Ontario government eliminated this exemption at the urging of the male-dominated profession of physicians who denigrated the skills and competence of such midwives. This change to the law rendered midwifery "alegal" since it was neither illegal nor legal.[319]

604. This "alegal" status served to discourage women from pursuing this work and denied many Ontario women access to midwife-led maternity care.[320] The legal exclusion of midwives from the health-care system and its public funding continued up to the regulation of midwives by the Ontario government in 1994. This exclusion was also reinforced by the government's historical and ongoing decision to give the male dominated profession of physicians exclusive control over admitting privileges to hospitals as provided by the *Public Hospitals Act* until it was amended in 1993.[321]

605. In 1983, the College of Physicians and Surgeons of Ontario passed a rule preventing doctors from attending home births. This rule remained in effect for many years and served to reinforce the view that home births were dangerous and that midwives were irresponsible for providing such care.[322]

606. The Task Force History Appendix also details how "medicalized childbirth multiplied its techniques after the turn of the century", which included Chloroform and forceps deliveries. As well, trained nurses became supports of doctor

---

317 "Task Force on the Implementation of Midwifery in Ontario" Affidavit of Jane Kilthei (Exhibit 1, Tab 8) at pp. 197-198, 212-215.

318 "Legislative Assembly, Official report of the Debates (Hansard), 35th Parl, 1st Sess (29 May 1991) (Hon. Frances Lankin)" Affidavit of Vicki Van Wagner (Exhibit 22, Tab 11); "Task Force on the Implementation of Midwifery in Ontario" Affidavit of Jane Kilthei (Exhibit 1, Tab 8) at pp. 206-207.

319 Chapters 1, 4, 7, 8 and 10 of I. Bourgeault, *Push! The Struggle for Midwifery in Ontario, (2006)* McGill-Queen's University Press: Quebec. (Exhibit 266) at p. 45; "Task Force on the Implementation of Midwifery in Ontario" Affidavit of Jane Kilthei (Exhibit 1, Tab 8) at Appendix 1 History of Midwifery.

320 Chapters 1, 4, 7, 8 and 10 of I. Bourgeault, *Push! The Struggle for Midwifery in Ontario, (2006)* McGill-Queen's University Press: Quebec. (Exhibit 266) at p. 45.

321 R.R.O.1990, Reg 965, s. 11(1)(c) (Exhibit 73) See Joint Book of Legislation, CMO Standards, and AOM Guidelines at L8.

322 Chapters 1, 4, 7, 8 and 10 of I. Bourgeault, *Push! The Struggle for Midwifery in Ontario, (2006)* McGill-Queen's University Press: Quebec. (Exhibit 266) at p. 45.

managed and nurse supported births which the History indicated had "its roots in the precariousness of the nurses' position in the emerging medical system." The history documents an ongoing public campaign over the 20th century about the benefits of medical birth care and the dangers of midwifery.

607. At the same time, the History Appendix documents the movement to address what was referred to as "cruelty in the maternity wards" including "strapping the mother to the delivery table, isolation of the mother, and slowing down the birth to wait for the doctor to come." The history noted that "decades of public education went into the effort of gaining public acceptance for medical birth. By the end of this period the traditional birth culture had largely lost its legitimacy…".[323]

608. Midwives such as Jane Kilthei, Bridget Lynch and Vicki Van Wagner testified in this hearing that their own observations and experiences with negative, medicalized birth experiences as mothers in the 1970's and 1980's led them to become midwives.[324]

609. Midwives testified to the overt hostility and prejudice they were subjected to during the pre-regulation period. The evidence heard states that midwives were viewed as "outside the system"[325] and considered untrained, unskilled, and a danger to women who were using their service and their newborn babies. These beliefs, attitudes and prejudices faced midwives in the community and in hospital settings.[326] Midwives testified about being met with hostility, abusive comments and lack of recognition and respect.[327] Midwife Elana Johnson testified about a very frightening and telling example from the late 80's, early 90's period.[328] Ms. Johnson described the incident in her testimony as "intense, difficult and feeling abused".[329] Ms. Johnson's testimony re-accounted the physical and abusive encounter she had with an angry male obstetrician who pushed her against the wall and demanded to know what she thought her role in obstetrics was[330].

---

323 "Task Force on the Implementation of Midwifery in Ontario" Affidavit of Jane Kilthei (Exhibit 1, Tab 8) at at pp. 212-227, 223 and 226.

324 Testimony of Jane Kilthei, Transcript, September 14, 2016, at p.9, Affidavit of Bridget Lynch, (Exhibit 61), at para. 27; Affidavit of Vicki Van Wagner, (Exhibit 22), at para. 36.

325 Testimony of Elana Johnson, Transcript, October 5, 2016, at pp. 6-13; Testimony of Katrina Kilroy October 6, 2016, at pp. 6-7; Testimony of Bridget Lynch, Transcript, September 22, 2016, at pp. 187-190.

326 Testimony of Elana Johnson, Transcript, October 5, 2016, at pp. 6-13; Testimony of Katrina Kilroy October 6, 2016, at pp. 6-7; Testimony of Bridget Lynch, Transcript, September 22, 2016 pp. 187-190.

327 Affidavit of Jane Kilthei, (Exhibit 1) at paras.82-84.

328 Testimony of Elana Johnson, Transcript, October 5, 2016, at pp.7-13.

329 Testimony of Elana Johnson, Transcript, October 5, 2016, at pp.7-13.

330 Testimony of Elana Johnson, Transcript, October 5, 2016, at pp.7-13.

C. Post-Regulation

610. In the early post-regulation period the hostility and prejudices towards midwives did not diminish. Midwives testified to being treated dismissively at hospitals[331].

611. An AOM President Elana Johnson testified to there being "a lot angst around midwives [coming to hospital] from home birth" during the early post-regulation period[332]. Ms. Johnson gave a compelling story that demonstrated how the animus towards midwives often had a direct effect on the women for which they were providing care. Ms. Johnson gave evidence about a specific example from the early post-regulation period when she arrived to the London, Ontario hospital she had privileges at. When Ms. Johnson transferred to the hospital with a client from a home birth she was met with an attitude that the hospital staff would now have to "clean up the mess [of midwives]." The obstetrician on call refused the consultation Ms. Johnson requested because the client had chosen a home birth with a midwife, there was a delay in this clients' care due to the obstetrician's refusal.

612. Ms. Johnson's example illustrates how the prejudice towards midwives directly impacted the care provided to women and individual midwives were left to their own diplomatic skills to re-strategize and negotiate to obtain care for their client when met with resistance. Ms. Johnson also gave evidence about the medical Resident in the above mention scenario equating home birth to "child abuse".[333]

613. Ms. Johnson also gave evidence about more than 10 years after regulation, it was still difficult for midwives to get hospital privileges and to be able to work to their full scope of practice in the hospital they get privileges in. Midwives also faced restrictions in hospitals on the number of midwives who can get privileges and practice in the hospital[334].

614. Madeline Clin, a rural midwife, testified that she experienced stereotyping, prejudices and disadvantages as a midwife continuing post-regulation. This often took the form of hostility from obstetricians and fellow nurses as well. Ms. Clin gave evidence that she frequently experienced physicians criticizing her practice in front of her client, which she observed was not a practice between physicians. Ms. Clin testified to it being apparent to her that she was not part of the physicians' world and was considered a lower status professional who was not accorded the respect and courtesy of a colleague.

---

331 Testimony of Bobbi Soderstrom, Transcript, September 21, 2016 at pp. 7-8; Testimony of Elana Johnson, Transcript, October 5, 2016, at pp.6-13.

332 Testimony of Elana Johnson, Transcript, October 5, 2016, at p.10.

333 Testimony of Elana Johnson, Transcript, October 5, 2016, at pp. 6-13.

334 Affidavit of Elana Johnson, (Exhibit 85), at para. 44.

615. Ms. Clin also gave evidence about being a nurse during the period 1994-1997 at Guelph General Hospital. In her evidence Ms. Clin stated that during her time as a nurse at Guelph General Hospital she frequently heard both physicians and nurses criticize the care of midwives with whom they had contact. Ms. Clin provided specific examples in her evidence of the comments made; “she is an idiot” - “she is incompetent”. Ms. Clin testified that felt like she I often had to defend midwifery when she was at work.[335] In Ms. Clin’s evidence from the 1998 to 1999 period she speaks being asked at the hospital if she had “left her Birkenstocks at home” and if she was a "lay midwife” and doctors making comments about “midwives being shoved down their throats.” Ms. Clin testified to feeling concerned about whether she would be able to stay in midwifery given the level of hostility but stated that support of her midwifery colleagues is what has gotten her through the years.[336]

616. Bridget Lynch, AOM President and later International Confederation of Midwives President, testified that she experienced the above stated conduct at the local hospital level, but also experienced it in her capacity as AOM President. [337] A specific example provided in Ms. Lynch’s evidence is, during her term as AOM President, Dr. R. Reid, the President of the Society of Obstetricians and Gynecologists for Canada wrote a policy statement regarding midwifery in 1998. The policy statement endorsed midwifery, but opposed home births "because of the potential risks to mother and fetus." Ms. Lynch testified to writing back to Dr. R. Reid, advising him that home births are "an essential aspect of a midwife's regulated scope of practice in Ontario" and that the statement provides "no research based evidence that midwife attended home birth is not an equivalent alternative to hospital birth for low risk women."[338] Ms. Lynch testified to the opposition to home birth by Obstetricians and Gynecologists and the media contributing to this debate lead to considerable barriers for midwives integrating into hospitals and the maternity care system.[339]

617. Bridget Lynch also testified to experiencing ongoing prejudices and hostility as well as frequent barriers to integration in hospital maternity care systems.[340] Ms. Lynch testified to experiencing stereotypes and prejudices post-regulation, including in her role as Head Midwife in three hospital settings from 1994 to

---

335 Affidavit Madeline Clin, (Exhibit 82), at paras. 25-29.

336 Testimony of Madeline Clin, Transcript, September 29, 2016, at pp.162-164

337 Affidavit of Bridget Lynch, (Exhibit 61), at para. 34.

338 “Letter to Dr. R. Reid, President, Society of Obstetricians and Gynecologists of Canada from AOM President Bridget Lynch re: SOGC's Policy Statement: Midwifery”, Affidavit of Bridget Lynch, (Exhibit 61, Tab 5) at p. 9.

339 “Toronto Star Article, "Controversy Lingers Over Role of Midwife", Affidavit of Bridget Lynch, (Exhibit 61, Tab 6) at p. 9.

340 Affidavit of Bridget Lynch, (Exhibit 61), at para. 36

2010.[341] She recalled constantly having to explain and defend the *Midwifery Act* and the College of Midwives of Ontario approved standards of practice to obstetricians who frequently refused to accept them and challenged the clear evidence that the standards were based on. She testified that the vast majority of obstetricians she dealt with continued to regard home births as not only unsafe but an irresponsible choice. Ms. Lynch describes her experience that the notion of empowering and providing women with information and respecting their informed decisions was disregarded by many obstetricians and considered an 'excuse' for the midwifery care she provided.[342]

618. Remi Ejiwunmi testified that she experiences stereotypes about midwifery over the 22 years after regulation.[343] Ms. Ejiwunmi testified to encountering barriers the over years to practicing midwifery at her local hospitals. She gave evidence about early on in her career many of her clients elected to go to the Mississauga Hospital because her practice group had the benefit of privileges there. She gave evidence that her practice group were not granted privileges at the other hospitals which meant that choosing to give birth there carried the risk of her clients losing access to midwifery led care.

619. Ms. Ejiwunmi testified to the barriers she and her practice group colleagues faced in integrating midwifery into their local hospitals. She testified that for a significant period, it was difficult to practice at William Osler Hospital because the administration capped the number of births that midwives could attend. She described that William Osler did an across the board cut to manage a budget deficit, and as a result midwives were capped. Ms. Ejiwunmi explained that technically obstetricians were also not allowed to expand their practices but in reality they have to serve women who come in regardless of the cap. As a result, her practice has been unable to grow sufficiently to meet the demand of local women for midwifery services and such women have been forced to use physician led maternity care.

620. Ms. Ejiwunmi also testified to serving as the Head of the Division of Midwifery within the Department of Obstetrics and Gynecology at Trillium Health Partners since 1996 and was not paid for the position till 2013. She explained that other physician department heads were paid throughout this time. In her evidence Ms. Ejiwunmi stated that for the first few years there was no formal midwifery head appointed by the Hospital. She explained that there was no formal "head" position for midwifery it only materialized because midwives had decided they needed a representative.

---

341 Bridget Lynch was the Head Midwife at St. Michael's Hospital (2005 – 2010), the first Head Midwife at Women's College Hospital (1996 - 1998) and the first Head Midwife at Wellesley Hospital (1994-1996). See Affidavit of Bridget Lynch, (Exhibit 61), at para. 33

342 Affidavit of Bridget Lynch, (Exhibit 61), at para. 33.

343 Affidavit of Remi Ejiwunmi, (Exhibit 66), at para. 22-34.

621. Midwife Carol Cameron testified about the work and research she did in 2005 on midwifery attrition[344]. Ms. Cameron gave evidence about how at the time of the research she herself was finding it "painful" to be in the profession and was contemplating leaving. Ms. Cameron testified to midwives she interviewed finding a "disparity" between what interviewees thought being a midwife would be and in reality what it was actually like[345]. One of the major reasons for this disparity Ms. Cameron said in her evidence was leavers of the profession she interviewed not being valued, feeling like an outsider in the health care system and lack of inter-professional respect from hospital staff[346]. Ms. Cameron in her evidence cites these reasons as significant contributing factors to the "wear and tear" midwives felt.

622. Ms. Cameron provided a further illustration:

> *imagine going into your workplace every morning knowing that you don't really belong there and that people don't really want you there. Imagine what that would feel like. It's like you have to put a flak jacket on at 8 o'clock every morning, and that's what it really felt like to people.*[347]

623. In her testimony Katrina Kilroy spoke of many of the reoccurring themes rooted in prejudice that still are present today. Ms. Kilroy gave evidence about an "integration survey" conducted by the Ontario Midwifery Program in 2007[348]. In her evidence Ms. Kilroy said that the survey was about scope, barriers to practice such as restrictions on the number of births midwives could. Ms. Kilroy gave evidence about interpreting the results of the survey as midwives still facing significant barriers in terms of integration and scope. Ms. Kilroy said though by this period several years after regulation there was some integration because "midwives had at least been able to get in the door" seeing this as "excellent integration" is gendered. Ms. Kilroy testified that as a midwife having a good working relationship and being in hospitals is coming a long way for midwives but that cannot take away from the fact that while midwives still face significant barriers in terms of practicing to their full legislated scope.

624. Ms. Kilroy also highlighted the extent of prejudices towards midwifery more than a decade after regulation. She testified to a specific example of in 2009 presenting on home birth to a group of physician leaders and making a joke about how midwives bring a kettle, bulb syringe and pair of scissors to a home birth and when they did not laugh, she realized that they thought she was

---

344 Affidavit of Carol Cameron, (Exhibit 44) at para. 25; Testimony of Carol Cameron, Transcript, September 22, 2016, at p.14.

345 Affidavit of Carol Cameron, (Exhibit 44) at para. 25; Testimony of Carol Cameron, Transcript, September 22, 2016, at p.14

346 Affidavit of Carol Cameron, (Exhibit 44) at para. 25.

347 Testimony of Carol Cameron, Transcript, September 22, 2016, at pp.14-19.

348 Testimony of Katrina Kilroy, Transcript, October 6, 2016, pp. 35-40.

serious. She realized at the time that even fifteen years after regulation and physicians were astonished that midwives took a complete set of modern equipment to home births.[349]

625. Ms. Kilroy testified to being hired as a consultant for a Health Force Ontario project in 2010 which was funded by the Ministry of Health and Long Term Care (MOHLTC). Ms. Kilroy's evidence stated that in her role she worked with 8 different Ontario hospitals to improve the quality of care provided in birthing units by exploring problems and proposing resolutions to inter-professional issues. These birthing unit teams typically included obstetricians, nurses, a chief of staff, midwives and sometimes family physicians. The project goal was to create plans that could be applicable to other hospitals. [350]

626. Ms. Kilroy testified that a reoccurring theme was voiced of not trusting the competence of midwives based on one experience with one midwife and as a result that one experience limiting the scope of midwives in hospitals. Ms. Kilroy provided the specific example of an error occurring with a midwife with regards to fetal heart monitor she said that in that instance the process should be some remediation for the weak clinician as would be the case for other clinicians. *[351]*

627. The current AOM president Ms. Elizabeth Brandeis testified to her perception and experience of the role that sex and gender has played is informed by the systemic disadvantages she experienced in the context of her being part of a small group of midwives in the hospital setting at Mount Sinai[352]. Ms. Brandeis testified to Mount Sinai Hospital like other hospitals has systems which place physicians in the dominant role, exercising significant control and influence. The department heads for Family Medicine and Obstetrics were male. While the obstetricians generally were approximately evenly distributed by gender, the Maternal Fetal Medicine Specialists, which are a subset of obstetricians, were highly male. In her evidence Ms. Brandies stated that the gendered context also arises because she advocates as a woman on behalf of my female clients and their newborn children.

628. Brandies also testified to particular examples in the hospital setting where she experienced systemic disadvantages compared to my obstetrical colleagues who also provide maternity care there.

629. At Mount Sinai there are hospital caps on midwifery courses of care. About 85% of the births at Mount Sinai are done by OBs with most of those being low risk. This distribution of work and the caps mean that the Collective must turn away a

---

349 Affidavit of Katrina Kilroy (Exhibit 91) at para. 121.

350 Affidavit of Katrina Kilroy (Exhibit 91) at para. 26.

351 Testimony of Katrina Kilroy, Transcript, October 6, 2016, pp. 35-40.

352 Affidavit of Elizabeth Brandeis (Exhibit 110) at para. 33-40.

substantial number of potential women who could otherwise receive midwifery care and improve the Hospital's maternity care outcomes;

630. The Head Midwife has no official standing and requests to have an official direct line to management have not been successful. The position is not paid whereas the Physician Heads are paid;

631. There is no direct channel for the head midwife to report to management although we have asked for one. Instead, the system is structured so that a physician - the Chief of Family Medicine department, is supposed to represent the interests of midwives at the Hospital.

632. This results in midwives' ideas for addressing issues re: pregnant women at hospital often being marginalized and not given respectful attention and consideration: For example a request to use midwives at Mount Sinai to improve work flow was rejected.

633. Brandeis testified that conduct such as reflected in the above examples lead her to feel that midwives such as herself are often just "a guest in someone else's house" and this impacts her professional autonomy and self-worth and respect. She believes this creates an atmosphere which works to justify her lower pay, given the systems which accord midwives' lower status.

634. Brandeis further testified to midwives still facing significant barriers in their practices. She gave evidence about some hospital Medical Advisory Committees (MACs) that continued to deny privileges to registered midwives and hospital department and physician policies that restrict the scope of midwives as defined by legislation and the CMO

635. Brandeis in her evidence said that OB departments often direct hospitals to restrict how a midwife can practice, resulting in midwives not being permitted to maintain primary care where an epidural is required or chosen or when oxytocin infusions are required for inductions or augmentations. Ms. Brandeis testified that in her observation and experience these restrictions are not based in medical need, nor are they evidence based.

636. Ms. Brandeis explained that despite the mandate of the OMP to facilitate the equitable integration of midwives, the Ministry has not acted to sufficiently address these structural barriers leaving midwives to face these systemic barriers. This has lead, in her observations, to: a) a resultant potential decrease to patient safety; (b) reduced access to midwifery care; and (c) increased costs to the health-care system due to double payment to the physicians for work midwives are already paid to do.

D. Summary of Post Regulation Ongoing Prejudice and Barriers

637. Midwives testified to encountering ongoing prejudices, disadvantages and barriers despite 20 years of integration in the health care system in Ontario[353]. Midwives testified that the animus from obstetricians, nurses and in hospital settings continued post-regulation and major misunderstandings and barriers still exist today.[354] Midwives testified to feeling as though the government had on paper integrated midwifery in 1994 but left it to midwives to fight the battles of having the profession accepted and attaining the ability to practice to a full scope.[355] There was testimony about still today being cautious of what say or do as there is a constant vulnerability of midwives not being perceived as a "safe care provider".[356]

638. These ongoing barriers and prejudices are also referred to in Appendix 5, Overview Summary of Evidence by Chronological Eras since 1994.

E. Prejudices and Misunderstanding about Efficacy and Safety of Home Birth

639. Midwives gave evidence about misunderstandings from the post-regulation period that still exist today about their profession and home birth[357]. There was testimony about even today midwifery clients going to medical settings such as labs for tests and being met with comments from other health care workers about the "dangers of midwifery" and home birth.[358] There was evidence from midwives about not being able to breakdown ongoing stereotypes; an example provided was a hearing from midwifery colleagues in certain hospitals today that they are still seen to be as representing the 50s and 60s stereotyped as the "hippy, granola crowd" and not for the well-educated, baccalaureate-prepared midwives that they are.[359] There was also evidence about a medical resident asking a midwife if "they [midwives] ate placentas"[360].

---

353 Affidavit of Vicki Van Wagner, (Exhibit 22), at para. 215; Affidavit of Remi Ejiwunmi, (Exhibit 66), at para. 22

354 Affidavit of Madeline Clin (Exhibit 82) at para. 25; Affidavit of Bridget Lynch, (Exhibit 61), at para. 36; Affidavit of Katrina Kilroy (Exhibit 91) at paras. 118 to 120.

355 Testimony of Testimony of Jacqueline Whitehead, Transcript, March 9, 2017,at pp. 33-34.

356 Testimony of Daya Lye, Transcript, March 10, 2017, pp. 20-21.

357 Testimony of Vicki Van Wagner, Transcript, September 16, 2016, pp.41-42; Affidavit of Bridget Lynch, (Exhibit 61), para. 34; Testimony of Bobbi Soderstrom, Transcript, September 21, 2016, pp. 7-8; Testimony of Katrina Kilroy, Transcript, October 7, 2016, pp. 8-9.

358 Testimony of Vicki Van Wagner, Transcript, September 16, 2016 pp. 41-42; Affidavit of Bridget Lynch, (Exhibit 61) at para.33

359 Testimony of Bobbi Soderstrom, Transcript, September 21, 2016, at pp. 7-8.

360 Testimony of Jacqueline Whitehead, Transcript, March 9, 2017,at pp. 33-34.

F. Barriers to Practicing to Full Scope and Caps on Midwifery Births at Hospitals

640. There was a range of testimony from midwives regarding the barrier to practicing within their full-scope and caps on the number of courses of care. There was testimony about difficulties of all midwives to get hospital privileges and to work to their full scope of practice in hospital they get privileges more than 10 years after regulation[361] as well as those difficulties still continuing to be barrier today.[362] The continued hospital restrictions and caps on courses of care impacts the ability of midwives to practice to their full scope of practice in all settings.[363] There was testimony about historical prejudices being carried with a midwife every time she enters a hospital and that continues if she eventually practices at a hospital she was previously denied privileges for any reason, she already starts at "a step down [from other providers]."[364]

G. Further Hospital Integration System Barriers

641. Midwives testified to the ongoing systemic lack of knowledge of midwifery still and to the prejudice still existing in hospitals today and creating barriers to midwives not playing administrative roles in hospitals to the same extent as physicians.[365] Midwives gave evidence about physicians being about to sit on the Medical Advisory Committee whereas midwives are with some exceptions barred from doing so.[366]

642. Midwives also testified to the lack of administrative opportunities for midwives in hospitals. There was evidence about Head of Division of Midwifery positions being unpaid, not having adequate support and having no official standing[367]. In evidence a further example of a barrier to integration was the lack of access midwives have to new computer equipment while other professionals like Family Health Teams have their computer systems funded. The lack of funding for new computer equipment results in midwives being asked to provide modern care with outdated record keeping and appointment scheduling. This also reinforces a

---

361 Affidavit of Elana Johnson, (Exhibit 85), at para. 44

362 Affidavit of Remi Ejiwunmi, (Exhibit 66), at para. 29.

363 Affidavit of Vicki Van Wagner, (Exhibit 22), at para. 215; Affidavit of Elana Johnson, (Exhibit 85), at para. 44; Affidavit of Remi Ejiwunmi, (Exhibit 66), at para. 31

364 Testimony of Daya Lye, Transcript, March 10, 2017, pp. 20-21.

365 Testimony of Bobbi Soderstrom, Transcript, September 21, 2016, pp. 7-8; Affidavit of Remi Ejiwunmi, (Exhibit 66), at para. 32; Affidavit of Elizabeth Brandeis (Exhibit 110) at para. 36.

366 Testimony of Bobbi Soderstrom, Transcript, September 21, 2016, pp. 7-8; Affidavit of Elizabeth Brandeis (Exhibit 110) at para. 38.

367 Affidavit of Elizabeth Brandeis (Exhibit 110) at para.40; Affidavit of Remi Ejiwunmi, (Exhibit 66), at para. 33.

historical and gendered stereotype that midwives are outdated, old-fashioned and technologically inept.[368]

H. Unequal pay sets low value

643. Midwives testified to the low value placed on their work by the Ministry contributing to the ranking of lower status professionals in hospital settings in terms of the lack of respect, understanding and attitude towards them and their practice. Midwives testified to not "being a part of the same world as physicians"[369] and feeling "like a guest in someone else's house's"[370] and such perceptions having an impact on the autonomy and self-worth of midwives.[371] There was testimony about feeling a direct correlation between compensation and treatment in hospitals in that if the Ministry does not value midwives enough to keep the pace of compensation then neither will hospitals in fully integrating the profession.[372]

I. Medically Unnecessary Transfers and Scope of Practice Restrictions

644. Another practice that continues to cause a barrier for midwives today is medically unnecessary transfers of care. Midwives, including Ms. Brandeis testified that the practice interferes with a woman's right to a midwife as her primary care provider during a low risk labour and birth. These unnecessary transfers may occur as a result of hospital policies set by the physicians which are not evidence-based, nor patient-centred and often contribute to greater physician income.[373] The unnecessary transfers may also result from a physician's decision to take over care and often to not transfer it back.

645. These unnecessary transfers violate the premise that childbearing belongs to the woman, and that she is the primary decision maker for her care. Ms. Brandeis testified that, these medically unnecessary transfers of care have the potential to decrease patient safety, as evidence demonstrates that each transfer of care increases the likelihood for communications breakdown, thereby potentially compromising care.

646. Midwives testified that these scope-of-practice restrictions force medically unnecessary transfers of care from the midwife as the primary care provider to the obstetrician. They also demean and undervalue midwives by implying that

---

368 Affidavit of Nicole Roach (Exhibit 241) at para. 78.

369 Affidavit Madeline Clin, (Exhibit 82), at para. 28,

370 Affidavit of Elizabeth Brandeis (exhibit 110) at para. 37

371 Affidavit Madeline Clin, (Exhibit 82), at para. 28, Affidavit of Elizabeth Brandeis (exhibit 110) at para.36

372 Testimony of Jacqueline Whitehead, Transcript, March 9, 2017,at pp. 33-34.

373 Affidavit of Elizabeth Brandeis (Exhibit 110) at para.41; Affidavit of Katrina Kilroy (Exhibit 91) at para. 130.

they are not competent to provide this type of care in spite of it being within their scope of practice.[374] Regarding unnecessary transfers Ms. Brandeis further testified that these lead to the MOHLTC paying physicians for work which they have already paid midwives to do.

647. In her evidence Ms. Brandeis says that the fact that the MOHLTC continues to allow this double payment to occur is very frustrating since it favours physician's increasing their incomes at the same time that midwives are told the Ministry has to freeze midwives pay and can't afford to make equity adjustments.[375] As well, these unnecessary transfers expose midwifery patients to having more interventive care and less good outcomes as midwifery has been shown to produce excellent outcomes and obstetrician care has higher rates of interventions.

648. Brandeis testified that unnecessary transfers violated the premise that childbearing belongs to the woman, and that she is the primary decision maker for her care. More importantly, these medically unnecessary transfers of care have the potential to decrease patient safety, as evidence demonstrates that each transfer of care increases the likelihood for communications breakdown, thereby potentially compromising care. Ms. Brandeis testified to the above cited actions or omissions to mean that midwives such as her colleagues and herself remain structurally and procedurally subordinate to physicians and have contributed to the failure to appropriately recognize the expertise and value of the female midwives.

J. Invisibility of Profession and Work

649. Midwives testified that they do not feel fully integrated into hospitals and often feel invisible from administrative and policy decisions which have implications on them. In her evidence Ms. Kilroy provided several examples of “invisibility” and marginalization:

(a) On lab forms there is often no provision for ordering by a midwife, only a physician.

(b) Hospital staff frequently ask patients, “Who’s your doctor?”

(c) New systems or technologies are rolled out at the hospital and you show up there for a birth and there’s a piece of equipment you’ve never seen and someone says, “Oh, we forgot to tell you…”

---

374 Affidavit of Katrina Kilroy (Exhibit 91) at para. 130; Affidavit of Elizabeth Brandeis (Exhibit 110) at para. 43.

375 Affidavit of Elizabeth Brandeis (Exhibit 110) at para. 43.

(d) Instructions to pregnant women by others in the health care system often include “ask your doctor…”

Politicians making promises about access to health care usually promise more doctors and nurses, in spite of the ongoing shortage of midwives.[376]

K. Hostility regarding the compensation of Midwives

650. Another re-occurring pattern of hostility towards midwives by physicians which has existed since the beginning of regulation is the common complaint by physicians that their compensation is lower than that of midwives.[377] Ms. Kilroy testified to hostility from physicians with respect to the compensation of midwives in comparison to the compensation of physicians. Ms. Kilroy testified that midwives receive a lot of negative treatment whenever their pay is compared to physicians. Ms. Kilroy stated that the hostility and attitude from physicians with an undertone of *“how dare you compare yourself to us [physicians]”*[378] minimizes and trivializes the work midwives do. Ms. Kilroy further testified that the attitude from physicians towards midwives is “what takes you so long to provide care to only 40 women?” this attitude devalues the model and the work that specifically leads to greater outcomes.

651. Another issue that midwives face hostility from physicians is the “comparison of the amounts paid according to fee codes.” In her testimony Ms. Kilroy spoke about this comparison that physicians have done from the time of regulation that “midwives are getting paid more than doctors because fee code [x], plus fee code [x] plus equals [the amount of fee code] so and so” and she said that this comparison makes invisible the vast amount of work that midwives do that is based on relationship building. Ms. Kilroy explained in her evidence said that the reason midwives achieve great outcomes is because of the relationship and trust they build with the client, “those are integral parts of midwifery care to create the environment where those kinds of outcomes are possible. So to just take that course of care and compare it to billing codes makes all of that work invisible."[379]

PART 22: A HIERARCHY OF GENDERED AND UNEQUAL CARE PROVIDERS AND MEDICAL DOMINANCE

A. The Power of Medical Dominance and How Government Sustains It

---

376 Affidavit of Katrina Kilroy (Exhibit 91) at para. 130; Affidavit of Elizabeth Brandeis (Exhibit 110) at para. 121.

377 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, pp. 109-112.

378 Testimony of Katrina Kilroy, Transcript, October 7, 2016, pp. 75-76.

379 Testimony of Katrina Kilroy, Transcript, October 7, 2016, pp. 29-30.

1. Introduction

652. There is a hierarchical structure within the health care system with the profession of physicians at the top and predominantly male.

653. This is experienced very directly by midwives who have had to struggle to gain integration into the maternal care system in Ontario and in particular in hospitals.[380] Midwives have experienced the most extreme form of medical dominance with their suppression as a profession for a good part of the 20th century. This dominance has continued. Physicians control the access of midwives to hospital privileges and the 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.

654. Dr. Ivy Bourgeault's reports and testimony set out in detail how the medical dominance has been structurally embedded in Ontario's health care system over time through laws, policies and practices which favour and privilege physicians and often disadvantage other health care providers.[381]

655. MOHLTC expert witness Dr. Candace Johnson agreed that organized medicine was *"dominant and institutionalized".*[382] She also said about the medical profession:

> *"… at a system level the medical profession is, in many ways, in a privileged position. In order to understand the Canadian health system at a very general level, it is important to recognize that organized medicine is central and dominant in many ways (ie. general practitioners serve as gatekeepers to specialist physicians' services; physicians' fee schedules are set by provincial governments in negotiation with medical associations; at the moment of the creation of public hospital and medical insurance only services provided in hospitals and by physicians (both in and out of hospitals) were covered)."*[383]

656. Dr. Johnson also stated:

---

380 "OMP Hospital Integration Surveys, 2009 and 2011", Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 107).

381 "Expert Report of Dr. Ivy Bourgeault, March 30, 2015," (Exhibit 265, Tab B); "Response Report to August, 2015 Ministry of Health and Long Term Care Expert Reports of Chaykowski, Kervin and Johnson, January 23, 2017," (Exhibit 265, Tab C).

382 "Expert Report of Dr. Candace Johnson – August 17, 2015," Affidavit of Candace Johnson, (Exhibit 274, Tab B) at para 4.

383 "Expert Report of Dr. Candace Johnson – August 17, 2015," Affidavit of Candace Johnson, (Exhibit 274, Tab B) at para 5.

"I would agree with Bourgeault's characterization of organized medicine as powerful and dominant in many regards (both in terms of its domain of authoritative (scientific) knowledge and its relationship with governments in Canada"

657. However, Dr. Johnson was not prepared to agree that this meant that "that the medical profession is in an inappropriate or unfair position relative to other practitioner groups."[384]

658. However, it is clear from Dr. Johnson's evidence that she has no knowledge or awareness of the actual operation of Ontario's hierarchical maternity care system and therefore is not in a position to provide any opinion which is helpful to the Tribunal on the issue.

659. Dr. Johnson in her report fails to consider how the privileged position of the medical profession may be sustaining inappropriately the pay gap between midwives and physicians.

B. Women in Male Dominated Fields of Work Benefit from Historic and Current Male Power and Privilege

660. All three MOHLTC CHC physician witnesses admitted that they have privilege by virtue of their position as physicians.[385]

I think doctors are granted a significant amount of privilege, both in society and I also think that within the relationship with our patients, we also have privilege and power. There's a power difference in the -- I mean, it's inherent in the definition. It's inherent in any expert role that there is a power difference. [386]

I think physicians wield a lot of power. Does that affect how we're compensated? I'm not sure…. I think it affects how we're perceived. I think it affects our ability to have our voices heard. So absolutely, I think the OMA ends us having a very strong voice because of the power that doctors wield. Absolutely.[387]

---

384 "Expert Report of Dr. Candace Johnson – August 17, 2015," Affidavit of Candace Johnson, (Exhibit 274, Tab B) at para 5.

385 Testimony of Tara Kiran, Transcript, November 10, 2016, at pp.156 – 160; Testimony of Susan Woolhouse, Transcript, November 9, 2016, at p.37; Testimony of Nicole Nitti, Transcript, November 10, 2016, at p. 44; Testimony of MaryRose Macdonald, Transcript, November 9, 2016, at p. 166.

386 Testimony of Susan Woolhouse, Transcript, November 9, 2016, at p.37.

387 Testimony of Susan Woolhouse, Transcript, November 9, 2016, at p. 98.

I also have the privilege of, you know, having a really respected -- highly respected place in society and my community and I really appreciate that.[388]

I've been on different kinds of health-related committees where I was the only physician sometimes and a physician's voice is loud. So, you know, one of the things we've been able to do is to make sure that like, you know, if we're trying to do an advocacy action, that the doctors are, you know, utilized and inserted at an opportune point.[389]

661. It is clear from the evidence that the increases in compensation which were afforded to the CHC physicians was connected to the alignment of their compensation with more predominantly male non CHC primary care physicians and with the role of the OMA as their bargaining representative bringing the power of the overall male predominant physician group.[390]

C. Physician Privilege and Dominance and Impact on Midwives

662. The evidence shows that midwives have experienced the gendered unequal power relations in many ways over the years both before and after regulation and continuing to this date.

D. Midwives' Experience of Physician Privilege and Dominance

663. Midwife Vicki Van Wagner testified to the privilege conferred upon physicians from the perspective of a non-physician health care professional:

Medicine was completely male-dominated at a time when, generally, women in our society had very little status, privilege, power, and although there has been a very encouraging, wonderful shift to more and more women entering medicine, there are elements of that gendered hierarchy that I see continue to exist and that what you would call male privilege continues to exist within the profession of medicine, regardless of the sex, gender of the person who is now a physician, and I think those things have ripples that probably will continue for a long time.[391]

……..

even in terms of going to a bank, a medical student has an ability to basically go into any of the chartered banks and get a line of credit. Midwifery students, there's a certain -- there's one bank that will do that. The rest of the banks won't,

---

388 Testimony of Nicole Nitti, Transcript, November 10, 2016, at p. 44.

389 Testimony of MaryRose Macdonald, Transcript, November 9, 2016, at p. 166.

390 See Affidavit of David Thornley, (Exhibit 178).

391 Testimony of Vicki Van Wagner, Transcript, September 16, 2016, at pp. 37 – 38.

and I would say this actually reflects some of just that embedded privilege that medicine has within our society.[392]

…….

So I think there are many, many examples of the way that kind of privileging of medicine, the normalization of, you know -- clients of ours can go to the lab and get their blood drawn and see that they have a midwife and encounter a health care worker within the hospital structure that says, "Isn't that dangerous? You shouldn't be going to a midwife. Don't have your baby in a hospital …don't have your baby at home. You need to be in the hospital." So those biases, those stereotypes persist, and we see it as a very long term project that we're engaged in because of that history.[393]

664. Midwife Elizabeth Brandeis testified:

My experience as a midwife in a male-dominated institution of the hospital was quite evident, starting to practice and actually even still today many years later, because of what I would describe as institutional male privilege. Of course, there are female physicians working at Mount Sinai and other hospitals, but it's quite stark as a small group of female professionals working in that hospital and working with women clients that much of the lack of access to power and influence that we felt in the hospital felt very much associated with our gender and with gendered behaviours that we encountered around that access to power and privilege, structures within the hospital.

Q. And why did you refer to Mount Sinai as male-dominated in paragraph 34?

A. Yes. As I said, of course, many of the physicians working in the hospital are female, but in the positions of authority and power, those positions were held by men in all of the strata of administration really. That's changed slightly over the years, but certainly in my early years of practising, the heads of departments were all male. The CEO of the hospital was male. Continues to be male.[394]

665. AOM Executive Director Kelly Stadelbauer, a former nurse testified:

…I've worked in and around health care for almost all of my career, except for that short detour off to the small business, and gender is the subtext in health care always, that the health care system is highly gendered and the occupations are segregated by gender…. What I mean by that is it's a known, when you're

---

392 Testimony of Vicki Van Wagner, Transcript, September 16, 2016, at pp. 165 - 166.

393 Testimony of Vicki Van Wagner, Transcript, September 16, 2016, at pp. 39 – 40.

394 Testimony of Elizabeth Brandeis, Transcript, October 7 2016, at pp. 87 -89.

working in health care, it's a known by the people that work in health care that nursing, for example, is over 90 percent female dominated, that midwifery is almost a hundred percent female dominated, that medicine is male dominated, and up until fairly recently in history was highly, highly male dominated, in other words, almost a hundred percent.

And there is such a long history of that male domination by the medical profession in the health care system, it is deeply embedded in the structures and the culture of the health care system, deeply embedded. And so there is this subtext when you're working in a hospital, when you're working in a Community Health Centre, when you're working in public health, there is a subtext of gender that is always there because the physicians had been male dominated for so long; nursing, midwifery and other professions, female dominated for so long.[395]

666. Other AOM witnesses also testified to these experiences as set out in the section below on the ongoing prejudices midwives have and are experiencing.

667. The experiences of Ontario's midwives are similar to the experiences worldwide of midwives which are detailed in World Health Organization documents.[396]

668. The relative lack of power of the midwives is reflected in a number of facts:

(a) To this date, midwives still continue to experience extensive integration barriers as detailed in MOHLTC hospital integration reports.[397]

(b) As well, midwives continue to experience ongoing differential access to policy influence and space in the political agenda and marginalization of their voices;

(c) The birth centres planned to open in the mid-1990's were cancelled and it took many years before even two birth centres were established again in 2012 in Ottawa and Toronto, despite the evidence of the efficacy of midwifery care and birth centres;[398]

669. Katrina Kilroy regarding physician privilege:

---

395 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, at pp. 20 -21.

396 Midwives Voices, Midwives Realities, Documents to Put to Candace Johnson, (Exhibit 275, Tab 2).

397 "OMP Hospital Integration Surveys, 2009 and 2011", Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 107).

398 See "Presentation to Health Education and Policy Committee on Establishing Midwifery-led Birth Centres in Ontario" Joint Book Of Cabinet Documents (Exhibit 141, Tab C88); Testimony of Martha Forestell, Transcript, March 24, 2017 at p. 34.

I believe the issues are systemic … It's about what is the power of a male-dominated institution? …They wield immense power and privilege in our society. They've been called by André Picard from the Globe and Mail, the OMA has been called the strongest lobby group in Canada. And it's clearly male-dominated the OMA. On their own Board they don't have proportionate numbers of women that are even in the profession. So, the profession carries with it male privilege.

And one of the things that's hard I would say for me personally is that the women in that profession don't recognize that privilege necessarily. I have seen examples, many, where, you know, it's like even in the affidavits from the CHC physicians, the female CHC physicians, there is almost this tone of like are they really trying to compare themselves to us? Right. Like, it's somehow an absurd thing to do to think that our work might be comparable, and we're not even saying it's equal, right, and I believe that that is male privilege. It's not about the individual person who is making that statement.[399]

……

A. I think what this communication was speaking to was Ms. Hendry, who was then the manager of the OMP, informing TPAs that this tool kit was available and that they should be aware of that and play a role in advocating on behalf of midwives.

Q. And why was it necessary to negotiate to have the tools?

A. I think that's linked to the OMA's objection, and that it's a delicate dance I think for all members in the health care system to recognize that the OMA is such a powerful body and that their opinion can really have that power and influence on all manner of decision-making in the health care system.

Q. How does that affect decision-making in the Ministry?

A. Well, I would -- I imagine that it affects decision-making in the Ministry because the OMA has that power and influence. So we know that they're a very powerful lobby body to the government, and that Ministry decisions are affected by their ability to advocate on behalf of their members.[400]

……

Q. Okay. All right. And paragraph 160, the last paragraph, you talk about experiencing great frustration and disrespect for the way you and your rural and remote colleagues had to fight for many years to getting small funding adjustments in relation to what happened to physicians; can you describe that for us?

---

399 Testimony of Katrina Kilroy, Transcript, October 6, 2016, at p. 34.

400 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at p. 101.

A. Well, I think when you read through some of these papers that the Ministry has produced, that the SOGC produced on their policy paper on rural and remote care, they were being -- the Ministry was being very proactive. They were looking for ways to get practitioners into these rural, remote, northern areas and they were doing nothing for us. In fact, they were making us feel bad for asking for anything. And that's the frustration is that you're working hard, you're trying -- we want to be able to work with these women, we enjoy that, but to be -- to be treated as if your care isn't important and that they aren't important is really frustrating.[401]

E. Physicians benefit from Stereotypes and biases

670. Physicians may benefit from numerous favourable stereotypes and biases in MOHLTC decision-making. These stereotypes and biases include perceptions of their importance in the healthcare system, which are reflected in public policy and legislation, statements by public officials, the over-broad legislative scope of practice, individual interactions. Mr. Durber described himself as suffering from this bias: "I rather suspect that I suffer from many of the same biases as many in our society which is that doctors are very important people in the system."[402]

671. Numerous public policies emphasize the role of physicians in healthcare by embedding their sectoral influence. Ms. Stadelbauer noted that the *Public Hospitals Act* gives physicians full control over Medical Advisory Committees and "the power to decide whether or not that midwife is privileged at that hospital."[403] Similarly, Premier Wynne has reflected this perceived importance by publicly characterizing physician negotiations as discussions to improve healthcare, not bargaining about compensation. Premier Wynne stated her desire to "return to the negotiating table to discuss <u>how we can work together to continue to improve our health care system</u> for everyone in Ontario [emphasis added]."[404]

672. Further, the broad legislatively-defined scope of practice and permitted acts, reinforces the stereotype of importance as it suggests the interchangeability of physicians with all healthcare providers. In reality, physicians' become specialists – "So although the scope of medicine is very broad, many physicians work in a much narrower scope."[405] It is only in theory that physicians work to their full scope and are interchangeable with other healthcare providers:

673. Physicians, theoretically speaking, in their scope could attend an out-of-hospital birth, but they are not trained and they do not do that… So although we may say,

---

401 Testimony of Madeleine Clin, Transcript, September 29, 2016, at p. 197.

402 Testimony of Paul Durber, Transcript, January 25, 2017 at pp. 494 – 496.

403 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016 at pp. 24 – 26.

404 Testimony of Robert Bass, Transcript, March 29, 2017 at p. 130.

405 Testimony of Vicki Van Wagner, Transcript, September 16, 2016, at pp. 79-82.

if we look at a view of authorized acts, that the scopes are the same, the roles, the jobs and the skills are quite different."[406]

674. Dr. Nicole Nitti was quoted in the Primary Care Nursing Task Force on the public stereotype of the family physician:

"She advocates for the empowerment of nurses because 'they are a key piece in a sustainable health care system in Canada.' But she acknowledges not all physicians are on board. 'Traditionally, primary care was the family doctor in the family doctor's office with the nurse sitting at the front desk,' she says. 'Our health care culture is really steeped in that. Focusing on team-based care requires a real shift in thinking.'"[407]

675. Physicians, the MOHLTC, and others in the healthcare sectors have become accustomed to physicians being in charge and learning to work around that. Elizabeth Brandeis testified that she had witnessed the OMA's objections to documents that promote midwifery as an excellent form of care. She testified that the OMA objected to the material because they perceived that it "diminished the role of physicians and the vital role that they play in maternity care as well.[408]

676. As Jane Kilthei noted, "[physicians] generally see the world through the lens of being the ones in charge. That's what has been inculcated in their medical training, and everyone else in the system generally learns to cater to that view in order to get things done."[409]

677. Stereotypes and biases can influence compensation, particularly when the compensation has not been subject to a skills, effort, responsibilities and working conditions assessment. Moshe Greengarten, principal at Hay, testified to this finding:

Based on our experience in evaluating physician roles, we have found that physicians in Ontario, which is where most of our work is, my work is taking place, are typically paid more than one would expect based on the results of job evaluation and internal relativity. We call that a market exception. So they are typically paid more. [410]

F. Power of Physicians, Medical Dominance and Exclusion and Suppression of Midwives

406 Testimony of Vicki Van Wagner, Transcript, September 16, 2016, at pp. 145-147.

407 Testimony of Nicole Nitti, Transcript, November 10, 2016 at pp. 78 – 81.

408 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at pp. 99- 100.

409 Testimony of Jane Kilthei, Transcript, September 14, 2016, at pp. 92 – 94.

410 Testimony of Moshe Greengarten, Transcript, October 13, 2016, at p. 255.

678. Dr. Armstrong testified to how the historical exclusion of midwives was related to the power of physicians:

Midwives have been excluded from practice in Ontario and in Canada except in the most undervalued regions of the country or locations of the country for a long time, whereas doctors, as Dr. David Naylor makes clear, have had an extraordinary amount of power and prestige from at least the 19th century, and that that has translated to a pay and other privileges. It's also translated into considerable authority. And as I quote in my report, the gentlemen were able to gain considerable status and power and compensation as a result of the fact that they were men in power, but also they then get to decide which other kinds of professions get to be professions under what conditions after that, whether you're talking about nurses or whether you're talking about midwives. And of course midwives come along as legitimated way later in Ontario or in Canada than nurses do, and have this history of exclusion... It takes a long time to overcome that history of exclusion, I think, and a history of denigration of your capacities and skills. It's been actually quite a brief time that they have been able to practise and gain legitimacy. When we were doing the study for the Transition Council …

Q. -- of the College of Midwives? Yes.

A. Sorry. And we were talking -- we were looking at the education program. We were looking at the certification and how were they to be regulated, and we interviewed a huge number of midwives and looked extensively at midwifery practice and talked a lot about the kinds of considerations that were going into the education of midwives. And one of the reasons we were told for going to university was to try and gain some of that legitimacy that doctors have had because there was -- there was a concern about access to universities, and whether universities being more expensive than colleges, for instance, whether that would make it more difficult for a broad range of women to become midwives, but one of the reasons for going for a university was this need to overcome this historical exclusion and to use this as yet another means of trying to get recognition.[411]

…….

in order to understand the Canadian health care system, it's important to know that organized medicine does have a privileged position in that system and its relationship with the state, although it has evolved over time as well, does make organized medicine a very powerful actor in the health system.[412]

[411] Testimony of Pat Armstrong, Transcript, March 20, 2017, at pp.19 - 21.

[412] Testimony of Candace Johnson, Transcript, March 23, 2017, at p. 26.

…….

the medical profession has been very powerful there, as they have been in other professions, in terms of determining who could do what.[413]

…….

Q. You agree medicine is dominant?

A. I agree that it is, in the context of a health care system, a powerful actor and dominant in that way.

Q. Okay. And you're not vilifying them when you say that?

A. No. I don't think that it is vilifying medicine to say they are a powerful actor in the Canadian health care system.

Q. Or dominant?

A. No.[414]

……..

So it became a very interesting case study because it was looking at a new set of factors within the state. When you're looking at turn of the century, turn of the 20th century, you know, women did not yet have the vote. Well, we had the vote when midwifery came in and, in fact, there was a confluence of what I refer to as sort of feminist and female factors within the state. You had members of the bureaucracy that were there wanting to advance a gender equity lens, gender equity initiative. You had members of the Ministry of Health, the Ministers of Health actively saying that they were feminist Ministers of Health, including Murray Elston,

the structures of our health system, the various elements of our health system were created at a time where medicine was, you know, the most, well, the dominant profession, and that the profession was almost exclusively male at that time, and the state was very much male at that time. You look at how, you know, physicians are integrated into hospitals. …So those are the historical policy legacies and it's written into funding, it's written into legislation, and variety of forms of legislation, so not just the Regulated Health Professions Act, for example, which got all revised which was, again, a way for midwifery to become integrated into the system through that whole review process….So all of those elements make up the system, and that's just a few examples, but the profession

---

413 Testimony of Pat Armstrong, Transcript, March 20, 2017, at pp. 218 – 219.

414 Testimony of Candace Johnson, Transcript, March 23, 2017, at p. 74.

of medicine is dominant in all of those pieces of legislation, and it reflects a time when medicine was predominantly male, and so it is both a structural embeddedness of medical dominance as well as the intersection with male dominance. There are I can say quite comfortably to my knowledge no health system of which medicine is not dominant, and of which medicine has not been -- that dominance of medicine has not been structured into the funding, the regulation, the structure of the health care system, the access to resources, et cetera, all of those elements of structural embeddedness.[415]

……..

Gender matters in terms of the access to resources by which one could translate a professional project into a monopoly in the market. So again, these are concepts that are applicable to those professions who, you know, were kind of first out of the gate and were able to secure monopoly over market in a particular sector before other professions, you know, came, you know, in subsequently.[416]

…….

These are systems that don't turn on a dime. They don't even turn on a hundred dollar bill. They are very slow moving, and when we talk about structural embeddedness of medical dominance and how gender is part of that, it takes a long time to shift practices because those structures are still in place supporting those practices.[417]

…….

How long does it take to change culture? It's also really important to understand that those women who went into medicine, we don't know, there isn't empirical data to say what their gender approach was. Some women go into male-dominated occupations and try to fit in. They work like a man, as they say. They study like a man. So they don't push back on the system based on their unique gendered experiences.

So I can't tell from a chart how many of these women in these early years versus later years, et cetera, would really push back at the very embedded, entrenched, gendered stereotypes that there are within medical school that have been identified in many studies that make it very challenging for women. You will always be able to find one, two, a handful of female physicians, as female academics, who have done very well. It doesn't mean that they haven't experienced gendered, uniquely gendered experiences such as sexual harassment, such as bullying, et cetera. It's not to say that men don't experience

---

415 Testimony of Ivy Bourgeault, Transcript, March 21, 2017, at pp. 29 -32.

416 Testimony of Ivy Bourgeault, Transcript, March 21, 2017, at pp. 67 - 68.

417 Testimony of Ivy Bourgeault, Transcript, March 21, 2017, at p. 155.

that either, but there are uniquely gendered experiences for women students within medicine as there are for women students in law, in academia, accounting, et cetera.[418]

679. Ms. Davey spoke to the gatekeeping role of the OMA with respect to how midwives could integrate into the system:

And I don't know, maybe you may have felt the same frustration, but when I looked at all the documents, started I think in '94 in attempting to get the ability of midwives to refer directly to specialists and not go through family physicians, it seemed an inordinate amount of time that it took and, essentially, it appeared blockage happened from the physician side.

A. Well, definitely, it took a long time and it was -- I'm sure it felt even longer to the midwives who were working in it….And it was not an ideal situation, but it did get resolved.

Q. All right. It may not have been an ideal situation, but the Ministry never imposed its position.

A. That's correct… Well, not to my knowledge. I mean, the Ministry is a big place.

Q. So it waited until they could finally get the agreement of the OMA to do it?

A. We pretty much had to have the agreement of the OMA to do it, given that it had to do with billing.[419]

PART 23: Unequal Bargaining Systems and Unequal Influence and Power of Midwives and Physicians and their Representative Organizations

A. Introduction

680. The Ministry has and continues to maintain a gendered and unequal bargaining and compensation/funding system for midwives who deliver its OMP program services. This system has contributed to the inequitable compensation midwives receive relative to other privileged and male predominant groups such as physicians and also the OPP with whom the Ontario government directly bargains.

B. Lack of Access to Regular and Equitable Bargaining System

418 Testimony of Ivy Bourgeault, Transcript, March 21, 2017, at pp. 156 - 157.

419 Testimony of Sue Davey, Transcript, October 20, 2016, at p. 182.

681. Courtyard Consultant John Ronson testified that the lack of regular negotiations and "paying attention to compensation levels and making sure that they were equitable relative to peer comparators" contributed to the need to recommend such as significant increase in pay at one time[420].

682. The Hay Reports also highlighted the inequitable impacts of the lack of a regular bargaining process and monitoring of compensation levels.[421]

683. MOHLTC expert Bass testified to the OPP situation where the government directly negotiates with their association to determine the pay which is then contained in a provincial collective agreement.[422] He acknowledged that the OPP has dispatchers and a variety of people that are female job classes and that their concerns about pay equity would be addressed separately from collective bargaining pursuant to the *Pay Equity Act* rather than using interest arbitration.

684. Mr. Bass, when asked "in this context setting about where a profession has been regulated, and then it provides the services the government wants provided, and it provides it through a contract relationship, are you aware of any other example like that", he was able to think of only one example that was similar to the midwives: "the only other contractor relationship that I'm aware of is the physicians…. That's the only one other."[423]

685. The lack of appropriate bargaining has caused a significant gender penalty to midwives, when compared to others in the health and social services sector. AOM expert witness Hugh Mackenzie looked at the midwives wages in relation to the health and social services sector to come up with a comparator that broadly reflected the universe in which the midwives were operating:

> *midwives are situated in a context of activities and people that are funded by the Ministry of Health, and the health and social assistance, or health and social services group in that average industrial wage calculation is -- that is the sector in which you would find …the overwhelming percentage of people who directly or indirectly are funded by the Ministry of Health… My conclusion was that the midwives' freeze lasted much longer than anybody else's. There was a period in which there was an adjustment that took place that reduced some of that gap, but then that gap has continued to widen ever since.*[424]

---

420 Testimony of John Ronson, Transcript, October 14, 2016, at p. 93.

421 "Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report" Affidavit of Moshe Greengarten (Exhibit 124 , Tab 4); "Association of Ontario Midwives – Compensation Review (June 2004) - Hay Group Report" Affidavit of Moshe Greengarten (Exhibit 124 , Tab 5).

422 Testimony of Robert Bass, Transcript, March 29, 2016, at p. 84.

423 Testimony of Robert Bass, Transcript, March 29, 2016, at p. 103.

424 Testimony of Hugh Mackenzie, Transcript, February 13, 2016, at p. 25.

C. 1993: The initial bargaining relationship

686. The initial bargaining relationship in 1993 was referred to in the September 1993 Cabinet submission as “collaborative negotiations”.[425] MOHLTC chose to work collaboratively with the AOM so that the midwives and community would perceive the payment levels as fair.[426]

687. Ms. Davey testified that her understanding of this process was the same as what was expressed in the MOHLTC cabinet document of September 20, 1993: "A funding mechanism for midwifery services was developed through a process of co-operative negotiation and consensus between the Ministry and the Association of Ontario Midwives."[427]

688. Following regulation, the MOHLTC characterized their bargaining relationship as at times consultative and but most often as negotiations. [428]. Ms. Lynch testified that the MOHLTC communicated in writing to the AOM “that they were not prepared to enter into formal negotiations with the AOM concerning the terms of the agreement, but that they were interested in consulting.”[429]

D. 1997 – 2005: MOHLTC ignores AOM calls for a negotiations process and compensation review

689. In 1997, the MOHLTC began to unilaterally draft a funding agreement that reflected the policy directive of devolution. The AOM communicated to the MOHLTC at that time that

> *the AOM membership rightfully expects a process which respects the input of those very midwives who are expected to sign the agreement. They have identified issues which require a response. It could make the difference between an overwhelming vote of ratification and a dissenting membership. As we move into this new Funding Agreement, it is important that we start with a unified membership who are willing to develop constructive relationships with future TPAs….*[430]

---

425 "Cabinet Submission, Ontario Midwifery Program Framework, September 1993", Documents to Put to MOHLTC Experts, (Exhibit 279, Tab 11)

426 Testimony of Sue Davey, Transcript, October 21, 2016, at p. 7.

427 Refer to Testimony of Sue Davey, Transcript, October 21, 2016, at p.73; "Midwifery Program Application and Report to Management Board - MB20 Request of Release from Holdback", Joint Book of Cabinet Documents, (Exhibit 141, Tab 34).

428 Testimony of Jody Porter, Transcript, February 21, 2016, at p. 211.

429 Testimony of Bridget Lynch, Transcript, September 22, 2016, at p. 200.

430 Testimony of Bridget Lynch Transcript, September 23, 2016, at p. 79.

690. Former AOM President Bridget Lynch testified to the growing frustration at that time by the AOM of the lack of a framework or process for bargaining the contract of midwives:

There is, in recognizing any profession, a respect that's inherent in recognizing a workload that is absolutely tied -- is fundamentally tied to compensation levels, and satisfaction with workload. And in the absence of having any kind of reliable manner in which -- in absence of having a framework within which we can continuously refer -- that we can continuously refer to, that will basically satisfy our professional needs to know that we are continuing to be respected as health care workers, without having to fight, without having to go, without having to bargain, I am not a union organizer….I was representing a professional health care organization but there was no money in our organization to hire somebody to negotiate on our behalf. Talk about gendered, we were so intimately gendered at that time, even in the fact that I was a woman, a mother, a midwife, giving to women, negotiating, doing the best that we could, we had three staff in our Association, plus a receptionist, and that was the sum total of the administrative support that we had in our organization. So, we were really dependent on the goodwill of the government that they would be protecting us as well as we moved through all of our negotiations.[431]

691. At the 2001 AOM symposium, Minister Tony Clement addressed the midwives. He directly spoke to the midwives concerns regarding compensation:

… this is where I reference the comment that the Minister had made at the symposium that there were other groups in line ahead of us, and that we understood that those groups had had their compensation issues addressed, and so we were now waiting patiently to be next in line.[…]

692. Former AOM President Remi Ejiwunmi testified to the further frustration of the AOM at the lack of attention and process for negotiations.

…We had come out of the devolution process, which happened at the end of the '90s, with an understanding that compensation would be addressed once the devolution process was complete, and we transitioned from the previous funding agreement to a contract agreement, and that didn't happen.

And then we had the symposium and we asked at that point in time for a compensation increase, and we were told that there were other people in line ahead of us. In the original funding framework there was a requirement for the Ministry to address cost of living increases as appropriate. And so when we started the discussion, because it seemed like there wasn't much movement on the actual compensation review process, we thought let's at least ask for a cost of living increase, but we were still the entire time also asking for a compensation review.

---

[431] Testimony of Bridget Lynch, Transcript, September 23, 2016, at p.175 – 176.

And that compensation review, although it didn't specifically ask for a pay equity review, was assumed to take the same format as the original review which included the notions of fair and appropriate, and that notion of appropriate as defined in the Morton report included skills, effort, responsibility and working conditions which are part of the pay equity framework.[432]

693. The AOHC had a MOHLTC funded compensation review undertaken by the Hay Group. The AOM asked the MOHLTC to fund a similar report but the MOHLTC refused; the AOM proceeded to commission a report from Hay.[433]

694. In 2005, with a decade of postponement, excuses, and delay, the AOM formulated a plan for a public demonstration to demand a compensation increase. This plan resulted in an eleventh hour deal, and a commitment to review compensation again by December 1, 2007.

695. The postponement of the inaugural negotiations meeting June 2008 by the MOHLTC caused much concern to the AOM. The MOHLTC cited re-organization issues, and those to be involved with the negotiations were not certain as to what processes should be followed. AOM Executive Director Kelly Stadelbauer testified to AOM's reaction to the MOHLTC's delay:

We were very concerned about the delays first because we were always thinking about the 11-year delay from the time of regulation to that first -- that first increase in 2005. And so we were just nervous in general about delays, that was this yet another delay and would it be another long, long period of time before midwives would be able to negotiate appropriate compensation?

We also had in the back of our mind our understanding in the 2005 negotiation that the government recognized that there was this compensation gap and that they couldn't address at all in 2005 but at the next negotiation it would be addressed.

And so it was our assumption that the Ministry was preparing for that, and that the Ministry was planning and budgeting accordingly and having recognized that there was a gap that they were taking that into account. So, as the summer of 2008 went on, and the financial crisis started to become more and more apparent... You know, in August we knew something was brewing for sure. And I think we were both nervous about that delay, you know, but also feeling a bit reassured that they would have done that budgeting already.[434]

696. The 2008 negotiations began in September and had all of the hallmarks of a genuine negotiations process. The MOHLTC appointed Mary Catherine

---

[432] Testimony of Remi Ejiwunmi, Transcript, September 29, 2016, at p. 39 - 40.

[433] Testimony of Remi Ejiwunmi Transcript, September 29, 2016, at p. 119 - 120.

[434] Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, at p. 38 - 39.

Lindbergh as the MOHLTC's lead negotiator. Negotiations were held over a series of meetings, and meaningful discussions were held regarding many issues:

.. it was groundbreaking, in that, we had this -- we had this contract, the MOU, that we've never had before with the Ministry of Health, that the Ministry of Health had engaged in a process, in a proper negotiations process that we had never had before. And so it did feel like it was groundbreaking in terms of how the Ministry was treating the AOM.

Q. That was an achievement?

A. We felt so, 15 years after regulation I'll note.[435]

697. However, the issue of pay equity or equitable compensation as a female predominant profession was not addressed, and there was no mechanism within the bargaining structure to address it. There was a commitment to re-negotiate by September 2010.

E. 2010: Midwives request for equity causes negotiations process to breakdown

698. In 2010, a negotiations process was initiated in October 2010 but was quickly de-railed by the MOHLTC's failure to address the Courtyard Report. Without a genuine bargaining process, the midwives then found themselves without a proper structure in which to bargain for either their contract or resolve the pay equity issue for the next six years. Ms. Kilroy testified to this lack of process during this time:

…As midwives, what process did we have? ... we tried very hard to establish that we had some rights to process at all… this is the only process we have that will address the question of equity and the question of sex-based discrimination, is here at the Human Rights Tribunal. We tried every other tool at our disposal. I wouldn't call them processes, but all of our opportunities to have dialogue, to speak directly to government representatives, to present arguments to the Public Service people who were in charge of what happened to us, to present to a third party person who could give advice and recommendations, to engage in political -- try and bring some political pressure to bear. We tried all of those processes and they were ineffective in establishing any -- bringing any equity lens or any gender lens from the Ministry to the work that we do, and that's why we're here…we have tried to assert our right to be involved in negotiations about our contract. The Ministry states that we are independent contractors, yet maintains this position that they can set the conditions of the contract. They may decide to

---

[435] Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, at p. 125 - 126.

dialogue with us or they may not. So I go back to my initial answer, which is none.[436]

699. The Compensation Restraint Legislation was introduced in March 2010. The AOM understood the legislation did not apply to the midwives as independent contractors; it was only in February of 2011 that the MOHLTC brought in a representative to explain the legislation to the AOM. The negotiations process came to a complete stand still in March 2011 as the MOHLTC tried to come up with an understanding and a process for negotiating with the midwives. For example, this correspondence from the Deputy Minister's office to the Primary Care Director, Mary Fleming:

"[Minister's Office] would like that you provide a one pager on how the Act does not apply to them but it does only from a policy perspective. Additionally, they want to know how are negotiations carried forward. Do they go to arbitration etc. A step by step of how negotiations with them take place ([that is the] authority that ministry engages with AOM directly, is this in a MOU etc)".[437]

700. A memo provided to the Deputy Minister's Office clearly states the Compensation Restraint Legislation did not apply to midwives despite what the AOM had been told by the MOHLTC: "Ontario registered midwives are self-employed and therefore are not captured under the Act."[438]

701. The same memo went on to say that the policy, however, did apply: "The Association of Ontario Midwives (AOM) bargains on behalf of the registered midwives in the province and as such, the policy applies to midwives." [439] This contradicts the previous statements from previous years that the MOHLTC does not negotiate but only consults and discusses, a statement that they will again perpetuate in later discussions with the AOM. This demonstrates either that the MOHLTC had no bargaining structure for the midwives or that they did but used it opportunistically as the situation presented.

F. 2011: Continued requests for equity but the MOHLTC provides no process

---

436 Testimony of Katrina Kilroy, Transcript, October 7, 2016, at p. 78 - 79.

437 RE: Midwifery update; email string with Khullar in MO and Fleming in PCHB, Government Documents - Laura Pinkney: Volume IV (Exhibit 160, Tab 221), at p. 3.

438 Midwifery Negotiations - MO Follow-Up, Government Documents - Laura Pinkney: Volume IV (Exhibit 160, Tab 224), at p. 1.

439 Midwifery Negotiations - MO Follow-Up, Government Documents - Laura Pinkney: Volume IV (Exhibit 160, Tab 224), at p. 1.

702. In May 2011, the AOM and the MOHLTC met. The MOHLTC proposed an offer than did not address the pay inequity identified by the Courtyard report.

Q. … it states here that: "The last negotiation meetings were held at the end of May...AOM [had] responded to the Ministry's 'offer' with three requests," which we just talked about before, and then it says: "The Ministry never responded to these requests and as a result, the negotiations have been on hold since the end of May. The Ministry never provided an official position on the compensation report..." And: "The Primary Health Care Branch...is seeking direction on how to approach the negotiations..." … And so did the negotiations resume at that point?

A. No, they did not. This was a draft that was still being … worked on as per the e-mail, but no, the negotiations did not restart at that point."[440]

703. The AOM provided a reply to the May 2011 offer from the MOHLTC.

Rather in response, the AOM sought the following three additional commitments from the Ministry: An official position on the compensation report; a 'trigger' or 'me too' provision in the agreement whereby any increases provided to doctors or nurses beyond the government's current compensation offer...would result in an inclusion of a provision for interest arbitration…the Ministry has not provided an official response on these additional requests.[441]

704. Ms. Farrell testified that this response by the AOM was rejected:

Q. So, then the last position is that you rejected the AOM's offer?

A. We rejected and we continue to reject unless something is to change, the inclusion of a provision for interest arbitration for midwives, binding compensation reviews, yeah.

Q. Any compensation increase was rejected.

A. And we are still under compensation restraint … maybe the last little while we've been seeing some movement on that.

Q. But I think you described that the midwives haven't received any movement.

A. Correct. There has been targeted movement on the compensation restraint, but up until very recently, compensation restraint was applied to everyone.[442]

---

440 Testimony of Transcript, Laura Pinkney, December 2, 2016, at p. 116.

441 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p.166 – 167.

442 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p.167 – 168.

705. The MOHLTC engaged in opportunistic behaviour by waiting for the ONA negotiations to be over and to delay negotiations in order to save money. Ms. Farrell was evasive during her testimony on this point:

Q. And: "This will provide time for the ministry to assess options against compensation packages for other health care professionals currently negotiating new contracts (e.g., nurses)." Do you recall, I think I recall this from some other document, that the Minister was interested in waiting until the ONA contract was finalized?

A. There was a comment in earlier briefing materials from the last day that we looked at, yes. […]

A. …Yes. Those were to be part of the negotiations, so if negotiations were delayed, they would be... -- delayed.

Q. So if you postponed them or if you put forward something that, really, you knew that midwives couldn't agree to, you would also be able to delay having to pay any of these things.

A. If negotiations were delayed as outlined here until the fall, then it would have delayed further making the final offer to the AOM.[443]

706. The AOM remained without a process to negotiate. Ms. Farrell testified that during this time: "We were still in the construct of compensation restraint and we had no mandate to go back and negotiate compensation increases".[444]

G. 2012 – 2013: Increased pressured by midwives for equity results in more hardline position by MOHLTC regarding bargaining process and rights

707. In late 2012, the MOHLTC, directed by the Minister's office, the Deputy Minister's office and the Health Human Resources Services Division contemplated replacing the AOM/MOHLTC Memorandum of Understanding dated May 7th, 2009, and

moving away from the current MOU with the AOM and a request was put into legal to rework a new document that effectively removed any commitment to negotiate regularly with the AOM for funding for midwife compensation. The attached accord was an attempt to address this request…Based on further

---

443 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 91.

444 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p. 155.

discussion we believe that this accord is not necessary as the letter from the Minister clearly lays out the Ministry's intention.[445]

708. In the end, this document was not produced because it was determined by the MOHLTC that they already had this right. However, the MOHLTC still planned to unilaterally replace the MOU.

Q. And then essentially it says the accord sets out the Ministry's commitment to ongoing dialogue support, strategic planning and issue resolution, but it doesn't commit the Ministry to negotiate…So, at one point there was an attempt to suggest you were going to have an accord that would take away the right to negotiate, and then it was decided you didn't need to do that?

A. Because the commitment to negotiating had not been provided, right.

Q.… this is actually an approved version of the accord dated December …"The Ministry's legal counsel has confirmed that the government does not have an obligation to negotiate with the AOM. As the transfer payment program, the funding for the midwifery program is based on the availability of funding as approved and allocated by Treasury Board. As such, levels of funding are not subject to formal negotiations." Right?

A. Right.

Q. All right. And then so if you go to the next page, the next steps are under paragraph 3: "The Legal Services Branch will be drafting an accord for the ministry to send to the AOM. This accord would replace the existing MOU." And "2" was just send a letter confirming that the agreement had been extended.

A. Correct.

Q. And then the top "Confidential Advice" was that: "The midwifery program area and LSB caution that presentation of this unilateral accord may offend the AOM and could negatively impact the Ministry's relationship with the AOM as the accord would signify a clear end to the old MOU. The AOM may point to previous correspondence from the Ministry whereby the Ministry committed to negotiate the terms of a new MOU in good faith, reference March 24, 2011, and that funding would continue but be subject to negotiated adjustments in a future MOU," referencing a March 20/12 document. And did you give any advice with respect to whether this accord should be done?

A. … it's all wrapped into the state of compensation restraint and the fact that, even if we're to sit down and talk about compensation, we are talking about zeros in terms of compensation. That is the continued conversation that we had

---

445 FW: AOM Documents for Minister Meeting on December 4th - DUE FRIDAY NOV 30th, Government Documents- Melissa Farrell- Volume I (Exhibit 182, Tab 27), at p.1.

in person about this and you're seeing in the back and forth that we were within the Ministry and our conversations associated with this, it's the same conversation about the circumstances then.[446]

709. Ms. Brandeis testified to the continuing path of the MOHLTC as midwives increased the pressure on the MOHLTC to provide equitable pay. In response, the MOHLTC became more entrenched in its position that it would not negotiate with the midwives, going as far as to direct MOHLTC staff not to use the word "negotiate". [447] The Ministry also told the AOM that the association was not the bargaining agent for midwives, and so negotiations will not occur. The AOM questioned Ms. Farrell about what would provide the AOM with that status. Ms. Brandeis testified to the MOHLTC's response:

we strongly articulated at that meeting that we believed that we were and that midwives believed that we were the bargaining agent, and she told us that because we're not unionized, we don't have collective bargaining power…[448]

710. The MCFAC minutes show that "The AOM requested dates for when formal negotiations would begin. "The Ministry indicated that the AOM is not recognized as the bargaining agent for midwives and therefore there is no formal mechanism for compensation negotiation. That said, the Ministry is prepared to meet regarding future funding, but cannot discuss compensation increases until the government's compensation restraint policy is lifted."[449]

711. Ms. Farrell testified that the MOHLTC had made this decision to go with the accord option and then reconsidered, [450] and that the status of the negotiations at that point was that there was still a freeze on negotiations.[451]

712. On April 18, 2013, the MOHLTC's Seetha Kumaresh reported to Ms. Farrell about a negotiations meeting that same day with the AOM:

We are looking to evergreen the agreement … rather than have time limited agreements that need to be renewed. They did not like this change as they want to have something in writing that would mandate the ministry to negotiate with them on compensation and other issues. We explained that MCFAC which is held quarterly was the means to have those discussions and update the agreement as necessary, but they didn't appear satisfied with this. It appears

---

446 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p. 171-174.

447 Testimony of Melissa Farrell Transcript, December 7, 2016, at p. 199.

448 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at p.109.

449 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at p. 125-126.

450 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p. 175.

451 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p.203.

they are looking for… an MOU that would commit us to negotiate and the time-limited funding agreement would ensure that we do negotiate.[452]

713. The AOM continued to seek a process whereby their working conditions related concerns could be addressed, and where their pay equity issues could be resolved. The MOHLTC continued to characterize the process as "discussions", denying midwives of their constitutional right to collectively bargain.

714. On May 30th, 2013 the Labour Relations Secretariat wrote to Ms. Farrell: "your message below sums up most of the points nicely. Our objective is to have a clear, factual and brief official response clarifying past messages and calling them on their tactics". While the OMA had close political contacts with the MOHLTC, the MOHLTC was irritated by the AOM's escalation of the issue to the political arm of the Ministry:

"Every time we talked to them, it escalated to the Premier's office and to the Minister's office. It felt like we didn't have a direct relationship with them. Everything that was said became something that then got communicated to the political side. It just felt like part of the tactic was that they were meeting with us because they needed to but who they really wanted to meet with was the political side[453]*.*

715. At the same time, Ms. Farrell testified that the MOHLTC program staff had been telling the AOM that in order to address the pay equity issue, the AOM would need the highest levels of the government to agree to get any significant adjustment.[454]

716. The lack of processes for bargaining put the midwives in a no win situation. They could not have their issues addressed at the program level nor at the political level without frustrating the program staff.

PART 24: HISTORY OF MIDWIFERY FROM SUPPRESSION TO 1992 AND START OF COMPENSATION AND FUNDING SETTING

A. Exclusion of Midwifery

717. The history of midwifery in Ontario and Canada is described in the 1987 Task Force on the Implementation of Midwifery which was appointed by the Ontario government. This Report has been repeatedly relied upon by the Government in its ongoing actions to regulate midwifery and provide its Ontario Midwifery

---

452 "Re: AOM Meeting Summary", Government Documents - Melissa Farrell - Volume I (Exhibit 182, Tab 63)

453 Testimony of Melissa Farrell Transcript, December 8, 2016, at p. 32.

454 Testimony of Melissa Farrell Transcript, December 8, 2016, at p. 33.

Program.[455] The AOM made submissions to that Task Force as did many of the AOM witnesses, including Vicki Van Wagner, Elana Johnson and Bobbi Soderstrom. The history of community midwifery in Ontario is also extensively reviewed in Van Wagner's "With Women: Community Midwifery in Ontario."[456] As well, Dr. Bourgeault's report and bush, Push extensively described this history.[457]

718. The details of this history to the end of 1992 and the start of the Joint Work Group, Morton Report and government September 1993 Ontario Midwifery Program Framework are set out in Appendix 7 to this Submission – History of Midwifery to 1992 – From Suppression to Re-Emergence of a Predominantly Female Profession. This history is briefly described below.

719. Prior to 1865, midwives were the primary maternity care providers in Ontario. Since that time, a male dominated physician profession became the predominant providers of maternity care. Male physicians actively sought status as experts in childbirth as it provided them with a steady income in communities.

B. Re-Emergence of Midwifery

720. Midwives were excluded from the Ontario Government's health care system and its funding for maternity care services until 1994. This exclusion was reinforced by the government's historical and ongoing decision to give the profession of physicians (as well as dentists) exclusive control over admitting privileges to hospitals as provided by the *Public Hospitals Act* until it was amended in 1993.[458] Until this was changed effective January 1, 1994, midwives were not able to provide the option of hospital birth to their clients.

721. Despite the above-noted exclusion, some midwives continued to practise in Ontario without legal recognition for more than a century. Particularly during the 1970's and 1980's, a growing number of Ontario midwives practiced midwifery but in a precarious fashion as a result of their uncertain legal status. Midwifery witnesses Vicki Van Wagner, Bobbi Soderstrom, Jane Kilthei, Bridget Lynch, Elana Johnson, Katrina Kilroy and Carol Cameron all practised prior to regulation.[459]

---

455 "Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], January 1, 1987", Affidavit of Jane Kilthei, (Exhibit 1, Tab 8).

456 "With Women: Community Midwifery in Ontario, M.A. Thesis, 1991" Affidavit of Jane Kilthei (Exhibit 1, Tab 16).

457 Chapters 1, 4, 7, 8 and 10 of I. Bourgeault, Push! The Struggle for Midwifery in Ontario, (2006) McGill-Queen's University Press: Quebec.(Exhibit 266).

458 R.R.O.1990, Reg 965, s. 11(1)(c)

459 Refer to Affidavit of Jane Kilthei, (Exhibit 1); Affidavit of Vicki Van Wagner, (Exhibit 22); Affidavit of Bobbi Soderstrom, (Exhibit 32); Affidavit of Carol Cameron, (Exhibit 44); Affidavit of Bridget

722. Midwives were in self-employed arrangements often working with a group of midwives. Vicki Van Wagner's "With Women: Community Midwifery in Ontario" describes the practice and conditions of midwifery during this time including the prejudices and stereotypes they faced. Such prejudices and stereotypes fomented by a health care system designed for and by men, became ingrained in that system through to today and reinforced negative attitudes towards the almost exclusively female midwifery profession.

723. Pre-regulation Ontario midwives, prior to being admitted to the Michener Institute program had been educated in midwifery knowledge and skills through diverse paths, including extensive apprenticeship to an experienced midwife, attending relevant maternal care related academic classes, qualifications and experience as internationally trained midwives and some with previously acquired nursing qualifications. Most had pre-existing university degrees.[460]

724. Midwifery apprenticeship learning was learning from an experienced professional over time in a clinical setting. As Vicki Van Wagner testified, it is similar to clinical learning. Clinical learning is a feature of both the education of midwives, nurses and physicians. Pre-regulation midwives such as Kilthei had been educated in midwifery in part through an extensive apprenticeship as well as the Michener program.

725. Van Wagner's With Women: Community Midwifery in Ontario also describes how midwives' exclusion from the funded health care system discouraged women from pursuing this work and denied many Ontario women, (particularly those unable to pay fees for midwifery out-of-pocket) access to midwife-led maternity care.

726. Midwives were either not paid or were privately paid low compensation by the women for whom they provided service to. While physicians were earning more than $100,000 annual incomes in the early 1990's receiving public funds for their insured services, the average earnings of a midwife in a very busy practice in Toronto was approximately $20,000[461] prior to regulation, while other practices fared much worse.

727. The exclusion of midwives from the regulated health professions had also served to perpetuate stereotypes and prejudices about midwives and reinforce the low value accorded to the wishes of women with respect to their health-care needs. This served to further the stereotype that women were not competent to make decisions regarding their own health care. It also promoted the view that women were not competent to act as autonomous health-care providers outside of

---

Lynch, (Exhibit 61); Affidavit of Elana Johnson, (Exhibit 85); Affidavit of Katrina Kilroy, (Exhibit 91).

460 Affidavit of Vicki Van Wagner (Exhibit 22) at para. 45.

461 Chapters 1, 4, 7, 8 and 10 of I. Bourgeault, Push! The Struggle for Midwifery in Ontario, (2006) McGill-Queen's University Press: Quebec.(Exhibit 266) at p. 90.

medicine, and that their health-care skills and knowledge were not as valuable, if valuable at all, in comparison to those of physicians.

PART 25: SETTING THE COMPENSATION AND FUNDING OF MIDWIVES ON REGULATION

A. Introduction

728. A key component of the equitable integration of midwifery into Ontario's health-care system was the setting of an equitable compensation for midwifery services. The need for such equitable compensation was called for in the 1987 Task Force report as well as in the IRCM Models of Payment and Practice report. Compensation reflects the value accorded to the profession in the health care system and sets the basis for the position of a profession within the health profession hierarchy.[462]

B. Positioning the Midwife between the Senior CHC Primary Care Nurse/Nurse Practitioner and the CHC Physician

729. There was discussion during the period around the Task Force and thereafter about the positioning of the midwife at greater than the senior nurse and less than the physician. While the formal designation of Nurse Practitioner was not recognized at that point, the Senior Primary Care Nurse was generally considered to be the equivalent of a nurse practitioner as the position operated at that time. See the Morton Report which refers to "Senior Nurse/Nurse Practitioner" in the schedule of salaries appended to the Report.[463] The relative position was also discussed in Van Wagner's thesis.[464]

730. When the time came to address the issue of funding and compensation, the Ministry had decided on a community-based system managed out of the Community Health Branch which also managed the Community Health Centres. This close connection between midwifery and the CHCs lead to the focus on the CHC Physician and Nurse Practitioner. Former Assistant Deputy Minister Jodey

462 Refer to "Expert Report of Dr. Pat Armstrong, March 3, 2015," (Exhibit 254, Tab B); "Response Report to August, 2015 Ministry of Health and Long Term Care Expert Reports of Bass and Chaykowski, January 11, 2017," (Exhibit 254, Tab C); "Expert Report of Dr. Ivy Bourgeault, March 30, 2015," (Exhibit 265, Tab B); "Response Report to August, 2015 Ministry of Health and Long Term Care Expert Reports of Chaykowski, Kervin and Johnson, January 23, 2017," (Exhibit 265, Tab C).

463 "Morton Report on Compensation for Midwives in Ontario, August 3, 1993", Affidavit of Sue Davey (Exhibit 135, Tab 23).

464 "With Women: Community Midwifery in Ontario, M.A. Thesis, 1991" Affidavit of Jane Kilthei (Exhibit 1, Tab 16).

Porter testified MOHLTC Minister Ruth Grier insisted that the CHC physician rather than fee for service physician comparator be used.[465]

731. This carried through to the discussions in the AOM's Funding Committee and ultimately in the Joint Funding Work Group of the AOM and the Community Health Branch. The Joint Work Group met frequently in 1993, most often at the Anne Johnston Health Station, a Community Health Centre in Toronto.

732. Various Community Health Centres were interested in integrating midwives into the primary care services offered by such Centres in the province as CHC employees.[466] As well, Jim Shea, one of the CHB lead funding negotiators also had a background in community health and was interested in integrating midwives into the system of CHCs.

C. The Focus on Gender and Pay Equity - "Equity for Midwives was the water we swam in"

733. Jane Kilthei testified to the central importance of addressing the equitable positioning of midwives at the outset of the regulation:

Well, we were certainly familiar with the skill, effort, responsibility, working conditions formula that was used in pay equity analysis, and it's hard to separate it out because for us, the issue of equity, equity for women, equity for midwives was the water we swam in…., it's the metaphor of a fish is not going to be talking about water... for us, I guess it would be the air we breathe.[467]

734. Ms. Kilthei testified that the language of skill and responsibility, education, realities of working on call, and the time intensive nature of midwifery care "is the language of pay equity…this was our clear statement about acknowledging the work of midwives with language that we associated with pay equity."[468]

A. And, again, it's familiar language, we recommend that funding must reflect midwives' level of skill and responsibility as primary caregivers.[469]

A…. pay equity was the whole context in which we were looking at this whole issue, and… it goes without saying that that's what we were talking about here.

---

465 Testimony of Jodey Porter, Transcript, February 2, 2017 at pp. 151-52, 220-21.

466 Affidavit of Jane Kilthei (Exhibit 1) at paras. 200-201. David Hole, the Chairman of the Network of Executive Directors, Eastern Ontario CHCs, the ED at the South East Ottawa Community Services wrote by letter dated September, 1993, to Jane Kilthei, the Community Health Branch, the Women's Health Bureau and others enclosing a proposal for such integration.

467 Testimony of Jane Kilthei, Transcript, September 15, 2017, at pp. 25 - 26.

468 Testimony of Jane Kilthei, Transcript, September 15, 2017, at p. 68.

469 Testimony of Jane Kilthei, Transcript, September 15, 2017, at p. 74.

Q. And none of the documents that I took you to refer to a need to redress the sexist wrong?

A. No. And that is not -- that was absolutely what we talked about amongst ourselves, and when you're an excluded, unfunded profession seeking to be part of the system, that is not language that we usually use in our documents where we're seeking to work co-operatively with them.[470]

735. In her testimony to the Tribunal, midwife Vicki Van Wagner provided a context for the 1993 Joint Funding Work Group and the Morton Report:

And so we were -- we were coming to the table, and this is where conversations that I had with whether it was people working in the Ministry of Health, the various coordinators for midwifery in the Women's Health Bureau, the consistent conversations that we had were constructive, and pay equity was mentioned. There was attention to midwives as autonomous primary caregivers. So, I had a fair amount of faith that we were dealing with people who had some integrity. So, I didn't feel the need, when I would have conversations with people at a fairly high level in government when they would assure me that pay equity was on their agenda, I didn't feel the need to follow up every one of those conversations with a memo saying -- referring to that conversation. It was just -- it was the context that we were in and the government seemed to us to be very committed to this from a point of principle.[471]

…It was a moment of optimism in the history of the women's movement, I would say, when we were making strides in many, many ways. And, you know, there were various people in the women's movement working on pay equity at the same time as we were working on midwifery issues. There were many women, people working on women's sexual and reproductive rights. There was a lot of work being done against violence against women. We saw that all as part of a cloth … We worked alongside within the Ministry of Health, feminists like Margaret Anne McHugh, like Jessica Hill, who was the head of the Women's Health Bureau at that time, who shared that kind of same atmosphere of we're all working on this together, all of these issues are integrated.[472]

736. Ms. Kilthei also had a strong memory for how pay equity influenced the process of compensation setting:

I am suggesting to you when they wrote that the Ministry should ensure an equitable formula for the funding of midwives be structured to fully support our recommended model of practice, that comes out of the discussion that we just read under the heading "Equitable Formula".

---

470 Testimony of Jane Kilthei, Transcript, September 15, 2017, at p. 152.

471 Testimony of Jane Kilthei, Transcript, September 15, 2017, at pp. 204-205.

472 Testimony of Vicki Van Wagner, Transcript, September 16, 2017, at pp. 56-57.

A. It does and the section following where it says, "We recommend that funding must reflect midwives' level of skill and responsibility as a primary caregiver, education at a baccalaureate level, the realities of working on call, and the time intensive nature of midwifery care," is also a bolded recommendation on that same page.

Q. It's a different recommendation, isn't it? It's the next numbered recommendation?

A. Right. And that's the one that most directly relates to pay equity.

Q. … I was only referring to the equitable funding formula recommendation…

A. And I agree that it is, as the IRCM's role was, the public interest looking at women's experience, all of that, and that was very important to the AOM as well, and those things, from our perspective as midwives, were always tied together with the next point.

Q. That was your perspective. That was the perspective that you brought to reading this document?

A. That was the perspective of the AOM at the time.[473]

D. Fall-Winter, 1992-93 – MOHLTC Funding Principles Development – Funding Options

737. The AOM's Kilthei and Eileen Hutton developed in 1992-1993 a document "Principles of Funding" which was ultimately later provided to the MOHLTC as set out below.[474] These “Principles of Funding Midwifery in Ontario” state that the principles of funding from the 1987 Task Force “be recognized in any funding mechanism”. Those were stated to include:

(a) that midwifery practice is based on a model of practice whether the “midwife follows the woman”;

(b) the “financial compensation fall between the level of a family practitioner and a senior salaried nurse”;

(c) “funding must reflect the midwives’ level of skills, and responsibilities as a primary care giver, education at a baccalaureate level, the realities of working on call and the time intensive nature of midwifery care;”

---

473 Testimony of Jane Kilthei, Transcript, September 15, 2017, at p. 47.

474 "Principles of funding midwifery in Ontario prepared by MOH Women's Health Bureau, January 1, 1992", Affidavit of Jane Kilthei, (Exhibit 1, Tab 76).

(d) "special consideration should be given to midwives working in under-serviced areas such as the north;" and

(e) an equitable funding formula will also take into consideration overhead costs, costs of setting up a new practice, travel, part time practice (including determinations of full time practice) and professional activities."

738. These Principles noted that the recommendations of the IRCM "Models of Practice and Payment - Recommendations" "are in line with the principles recommended in this paper". The document also refers to opposition of the OMA and the College of Physician and Surgeons of Ontario in principle to home birth and concern about the liability questions associated with the transfer of care from a midwife to a physician.

739. The MOHLTC, working from principles developed over the pre-regulation process, developed its own funding principles which were circulated by ADM Jodey Porter in early Fall, 1993.

740. A November, 1992 memo from Anne Premi set out the budgetary analysis for the annual Estimates Process. This analysis which was co-authored by AOM witness Margaret Anne McHugh, Midwifery Implementation Coordinator within the Women's Health Branch estimated the budget based on a salary for midwives of $60,000 to $80,000.

741. On December 15, 1992 McHugh met with Jane Kilthei and Eileen Hutton to discuss two AOM documents, "Principles of Funding Midwifery in Ontario"[475] and "Possible Mechanisms for Payment of Midwives", which referenced the 1987 Task Force Report and the IRCM's "Models of Practice and Payment". At that meeting they discussed how midwifery might fit within the Community Health Branch, particularly the CHB's support for community-based practice and care for refugees and vulnerable populations.

742. On December 17, 1992 McHugh and representatives of the Community Heath Branch met to discuss the implementation of regulated midwifery services in Ontario Jane Kilthei spoke with McHugh after that meeting and McHugh indicated that there was some interest expressed in the potential for midwifery working within CHCs and their branch.[476] This lead to the decision that McHugh would develop an Options Paper.

E. The Women's Health Bureau and the 1993 Options Paper

475 "Principles of funding midwifery in Ontario prepared by MOH Women's Health Bureau, January 1, 1992", Affidavit of Jane Kilthei, (Exhibit 1, Tab 76).

476 "Meeting materials for Models of Funding Meeting on December 17, 1992 sent from Anne Premi, A/Mgr of Women's Health Bureau" Affidavit of Sue Davey (Exhibit 135, Tab 8)

743. Minister of Health Frances Lankin committed to publically funding midwives.[477] The Women's Health Bureau was designated to take the lead in identifying the possible funding mechanisms with the idea that the Community Health Branch would ultimately take on the responsibility for the funding.[478]

744. Ms. McHugh testified to the role of the Women's Health Bureau in relation to midwifery:

It was to get it done, to get midwifery implemented as a new profession in Ontario and get all the pieces that were not working out of the way. Everything we did had to be approved by director, ADM, deputy, but we were in the central co-ordinating, controlling, getting information, packaging it up, et cetera.[479]

745. Ms. McHugh testified about the work in the Women's Health Bureau: “a lot of people spoke about gender in relation to midwifery, and looked at gender, particularly in relation to midwifery because it was almost exclusively women, not just dominated by women”.[480]

746. Ms. McHugh was the author of the January, 1993 MOHLTC approved document "Midwifery Payment", "An Options Paper."[481] In the final paper, under the heading of "Assumptions" the document states: "Necessity to establish a fair and equitable pay level based on pay equity, reflecting responsibilities, working conditions and level of education." Ms. McHugh testified that this was an assumption” right from the political level right down through the Ministry”. She was clear in her testimony that it was an assumption that

we were going to look at things using a gender analysis for most health policy, not just ours, so that was true throughout the Ministry. People would often in, you know, the hospital branch would have to say what the impact on women would be for a change in policy. So it was there throughout the Ministry that women were special and had to be looked at from the government, from the Minister, from the Ministry, and then because we were the Women's Health Bureau, we were set up explicitly to look at women and their provision of service, their -- the service they were provided, practitioners and their impacts on women, and also women as practitioners.

So all those things were happening in the Women's Health Bureau with a specific focus on making sure that a new profession was set up that was a female-dominated, in fact almost female-exclusive profession, that it would not be underpaid simply because it was a female-dominated profession…that appeared

---

477 Testimony of Anne Premi, Transcript, February 22, 2017, at p.18.

478 Testimony of Anne Premi, Transcript, February 22, 2017, at p. 18.

479 Testimony of Margaret Anne McHugh, Transcript, February 21, 2017, at p. 14.

480 Testimony of Margaret Anne McHugh, Transcript, February 21, 2017, at p. 42.

481 Testimony of Margaret Anne McHugh, Transcript, February 21, 2017, at p.52.

to be true from the Premier's Office right through, down through the bureaucracy, not necessarily specifically about midwifery, but that we make sure in any way that we were doing it.[482]

747. Ms. Davey testimony regarding the role of the Women's Health Bureau, seems disingenuous for an experienced bureaucrat responsible for the midwifery file:

Q…what did you understand to be the reason why the Women's Health Bureau had been given the lead before?

A. I don't think I ever really thought about it, and so I would just be speculating why they were given the lead…Anyone could speculate it's about women, but they weren't necessarily given -- they certainly weren't given the lead when we were looking at nurse practitioners, so I'm not sure why it went to the Women's Health Bureau. It could have gone lots of places in the Ministry.[483]

748. Ms. McHugh was asked what she understood the term "pay equity" to mean in the context of the Options paper:

We understood it to mean that women had historically been underpaid and their work had been undervalued, and if we were going to establish a brand new, female exclusive-almost profession, that we had to ensure that that profession was not going to be discriminated against or that there wouldn't be bias against their payment method just by looking at other female-dominated professions and kind of going, "Oh, well, you know, you should be paid a small amount since you're women." So we had to make sure that that happened. It didn't necessarily mean that we were going to do a formal pay equity assessment under the [Pay Equity] Act. It meant that we were going to make sure that we were not underpaying midwives, that they were fairly and equitably paid according to their skills and experience and education, and not according to somebody's picking out something. It was going to be evidence-based.[484]

749. The paper stated:

The Ministry may wish to have a formal pay equity assessment done of the role of the midwife. Pay Equity, an approach to setting compensation rates that bases the value of the remuneration on the work performed regardless of gender, is an important consideration in the setting of payment rates for midwives. Pay Equity addresses the fact that work that has traditionally been done by women tends to be undervalued."[485]

---

482 Testimony of Margaret Anne McHugh, Transcript, February 21, 2017, at pp.20 -21.

483 Testimony of Sue Davey, Transcript, October 20, 2017, at pp.184 – 185.

484 Testimony of Margaret Anne McHugh, Transcript, February 21, 2017, at pp. 21 – 22.

485 Testimony of Margaret Anne McHugh, Transcript, February 21, 2017, at pp. 22 – 23.

I would create the draft of the options paper, Anne Premi would probably have commented on it, maybe given it back to me for a rewrite. Once she approved it -- I don't know that that happened. That's just the normal course of events. Once the manager approved it, it would go to the director for approval. When the director approved it, it would go on to the ADM's office for approval, and the ADM would have to approve it going to the Deputy Minister's Committee and the Minister's Policy Committee.[486]

…I don't recall anyone pushing back at all on pay equity, and I think I would recall it because it was part of our kind of way of being at Women's Health Bureau, so if somebody was like, "No, we're not using pay equity. We're not going to assess, like, whether or not they should be paid appropriately or assessed in terms of gender to make sure they're not being discriminated against on a gender basis," I think I would remember that, so I have no recall of it.…

750. Ms. Premi testified that the principles in the Options Paper were developed and intended to be foundational, and that these principles were to govern the joint working group process.[487]

751. Ms. McHugh explained why there was minimal material in the Deputy Minister's briefing including the absence of the concept of pay equity:

You have, like, 10 minutes for a presentation of the Deputy Minister's Committee and you're only allowed three slides…there's no point in sending reams of stuff that's either already agreed to or it's not going to be relevant to the discussion, not that it's not relevant to the issue, but relevant to the discussion.…So a lot of the background came out because they already knew all of that.[488]

752. McHugh testified that to the process of finalizing the Options Paper:

was approved by the ADM to go to the MPC and the DMC.…And in my mind, the decisions, you know, sort of were the decisions that were recommended in the options paper. So I'm not sure that I could say with authority that everything in the options paper was then, therefore, accepted as gospel for evermore because it's not in the minutes, but that was pretty standard …kind of practice where there would be a longer version or a longer paper …go that was supposed to be reviewed before the meeting, and then that would allow them to ask questions…at the meeting.[489]

753. ADM Jodey Porter took issue with Ms. McHugh characterization of pay equity as a concept within the Options Paper, but her rationale was weak:

---

[486] Testimony of Margaret Anne McHugh, Transcript, February 21, 2017, at p. 25.

[487] Testimony of Anne Premi, Transcript, February 22, 2017, at p.18.

[488] Testimony of Margaret Anne McHugh, Transcript, February 21, 2017, at pp. 90 - 91.

[489] Testimony of Margaret Anne McHugh, Transcript, February 21, 2017, at pp.120 - 121.

Q. … looking at page 6 of that document …the assumptions that are set out there state: "Necessity to establish a fair and equitable pay level based on pay equity, reflecting responsibilities, working conditions and level of education." And I think you said in your affidavit that you didn't know what term -- what the -- Ms. McHugh was meaning by that.

A. That's correct. I don't know if she was meaning a formal pay equity exercise or an exercise that would help determine equity that included reflecting responsibilities, working conditions and level of education. So if she means pay equity being reflecting responsibilities, working conditions and level of education, I understand that.

Q. Okay.

A. But I don't know if that's what she meant.

Q. Okay, and did you ever ask her?

A. No.[490]

754. Ms. Porter conceded that there could have been discussions about pay equity in midwifery that she was not part of, for example, at the Women's Health Bureau. Ms. Porter also stated that she had no recollection of whether, at the time, she agreed or disagreed with certain statements put forward to her by AOM's counsel, specifically:

- *March 24th, 1991 document. Under "Options for calculating pay rates", sub (b) is "Pay equity": "Payment for midwives must conform to existing guidelines for pay equity. Obviously, midwives will almost invariably be women. Calculations are based on the principles of skill, effort, responsibility and working conditions. These principles can be further broken down to consider issues such as educational requirements, actual duties, the responsibility assumed by the practitioner, and the hours, times and regularity of working life. The rate of pay is then determined in comparison with other pay rates for similar work."*[491]

- *"Payment for midwives must conform to existing guidelines for pay equity." And I'm quoting from the Midwifery Funding Paper Draft #1, dated March 24, 1991, which is tab 1 of Exhibit 142. "Obviously, midwives will almost invariably be women. Calculations are based on the principles of skill, effort, responsibility and working conditions. These principles can be further broken down to consider issues such as educational requirements, actual duties, the responsibility assumed by the practitioner, and the hours, times and regularity of working life.*

490 Testimony of Jodey Porter, Transcript, February 21, 2017, at pp. 183 – 184.

491 Testimony of Jodey Porter, Transcript, February 21, 2017, at pp.177 – 178.

The rate of pay is then determined in comparison with other pay rates for similar work."[492]

755. In contrast, Ms. McHugh had a strong recollection and handle on how pay equity influenced the Options Paper:

Q. And those funding principles, can you tell us why there is no specific reference to the term "pay equity" in those principles?

A. Well, if you -- when you find them in points 2 and 3… that is where I see pay equity embedded throughout, and we often will…talk about issues of equity related to both us as midwives and primary caregivers and women in being treated equitably and respectfully as autonomous decision-makers as a whole framework of...

Q. And so if you look at paragraph 206 of your affidavit, it actually has the text of the Principles of Funding there, and you were referring to which two paragraphs?

A. 2 and 3 is where I see it's setting out the midwives' role in care and the midwife as a primary care provider, and the importance of equity in terms of wherever a midwife practised, whether they're in a small community in the north or the south, that it needed to be equitable, and to say that the funding arrangement acknowledged midwives as autonomous practitioners, and this is where we referred to skill and responsibility, education, working conditions. I mean, that's us talking about pay equity.

Q. Right. And what did you understand would have been the government's role at this time in relation to pay equity and midwives?

A. Well, we were very aware of cases that were ongoing in terms of looking at nursing and pay equity. It really seemed to us that there was a very strong commitment and that as midwifery was probably the most female-dominant health care profession that they'd ever had to deal with, it just -- we didn't question that the ministry would be addressing pay equity….So, the whole landscape around pay equity was at a point of change when this was happening. It was happening but they do not speak to that, no. And even in the absence of bringing a pay equity lens to the report, they were very clear that the level of remuneration for midwives, that the salaries paid to nurses was not adequate.[493]

Q. And the next one is part-time, that the equitable funding formula would have to be able to accommodate part-time as well as full-time midwives; that again is two different groups of midwives?

---

492 Testimony of Jodey Porter, Transcript, February 21, 2017, at pp. 177 – 178.

493 Testimony of Jane Kilthei, Transcript, September 15, 2017, at p. 27.

A. It's actually the same group of midwives and it's about flexibility. And one of the big pieces, I mean, some of it had to do with midwives who were working teaching in the midwifery education program and wanting those midwives to continue to practice. It also had a lot to do with midwives being an almost exclusively female profession and having children, maternity leaves, and moving in and out of practice, so yes.

F. The Midwifery Funding Work Group and the Morton Report

756. The MOH established a joint Midwifery Funding Work Group in April, 1993 whose purpose was to work on creating recommendations for a framework for the funding of midwifery services. This led ultimately to the issuance by the MOH of the September 1993 Midwifery Program Framework. The AOM representatives to this Work Group included Jane Kilthei. Kilthei as AOM President was the lead negotiator for the AOM. The AOM's Funding Committee also included Vicki Van Wagner, Bobbi Soderstrom and Carol Cameron. The MOH CHB representatives were Sue Davey and Jim Shea.[494]

757. By letter dated March 26, 1993, Dorothy Loranger, Director of the Community Health Branch wrote to Jane Kilthei to advise that the CHB had been asked to develop, in association with relevant partners, the funding arrangements for midwives in Ontario and asking the AOM to participate in that project. Jim Shea, CHB Senior Policy and Planning Analyst had been asked to take the lead in the process.

758. Jane Kilthei replied to Ms. Loranger by letter dated April 12, 1993 advising that the AOM was ready and willing to participate in the process. Kilthei advised that the AOM was anxious to:

"to establish with your government a co-operative process to negotiate a funding arrangement that will provide a solid base for midwifery services to the women of Ontario. One of our primary objectives is creating an arrangement that supports the Ontario model of midwifery practice. We will work closely with Mr. Shea to discuss principles and establish the process and time lines to ensure funding arrangements are in place as soon as possible."

759. As set out below, Jane Kilthei testified that she met with Jim Shea for lunch to discuss the Work Group on April 21, 1993. She testified that the issue of pay equity raised in this meeting.

We talked broadly about issues of equity and gender equity, and other issues of systemic equity in society on that -- at that lunch meeting, and it was in a call just prior to bringing Robert Morton on board where I recall him using the phrase "pay

494 "Letter from AOM President Jane Kilthei AOM to Dorothy Loranger Director CHB re: accepting invite to participate in working out the funding arrangements for Midwifery Funding, (April 12, 1993)", Affidavit of Jane Kilthei, (Exhibit 1, Tab 92).

equity exercise" because he was speaking specifically about his plan to bring Robert Morton in....[495]

At that point in time I assumed it was the best we could do. We were on a very tight timeline that we had done an exercise where we were satisfied we had made some progress towards pay equity, and I was -- I was, in the circumstances of the day, I was quite happy to recommend it to the members as I believed it was the best we could do.[496]

760. On May 5, 1993 a meeting of a Midwifery Reference Group took place. This meeting included Midwifery Implementation Coordinator McHugh, policy staff from the Minister's office, Community Health Branch Director Loranger and Policy Director Shea, as well as Ministry representatives from Birth Centres, Institution Planning and Health Strategies, IRCM Chair Mary Eberts, Dianne Pudas the MTFO representative on the IRCM and Jane Kilthei and Carol Cameron from the AOM along with their legal counsel Rick Salter and MOH lawyer David Bernstein. This group was established as a reference group for the negotiations should there be difficulties, but it was not convened again.

761. Starting in May and through the summer of 1993, the Joint Work Group met frequently (mostly at the Health Station CHC) to try to work out the details of funding implementation with a target date of starting regulated practice on January 1, 1994.

762. The AOM provided the CHB with its April, 1993 document "Principles of Funding" which it proposed as the guiding principles for the upcoming funding discussions.[497] These principles included: a) that the compensation and funding model should serve firstly to further and be consistent with the Midwifery model of care and CMO requirements; b) that the compensation should be the same level regardless of the setting or employment circumstances in which the midwife practices; c) midwives are autonomous practitioners; d) there should be assessment of skill, effort, responsibility and working conditions of midwives to ensure equitable compensation and operating costs and expenses; e) two midwives at birth – a primary and secondary midwife; f) the compensation is structure to permit part time work; g) provides sufficient access of midwives to other maternity care providers; and h) the importance of a central negotiation process by the AOM with the MOHLTC regardless of the funding model in order

---

495 Testimony of Jane Kilthei, Transcript, September 15, 2017, at pp. 154 – 155.

496 Testimony of Jane Kilthei, Transcript, September 15, 2017, at pp. 168 – 169.

497 "Principles of funding midwifery in Ontario prepared by MOH Women's Health Bureau, January 1, 1992", Affidavit of Jane Kilthei, (Exhibit 1, Tab 76).

to ensure that the new small and vulnerable female profession was adequately represented and equitably treated.[498]

763. The AOM recognized that it did not have the same bargaining power as the OMA and that it was a small vulnerable profession. The AOM members of the Joint Funding Group therefore approached the issue of developing the funding terms from a perspective of principle and equity as it sought to establish the place of an almost exclusively female predominant profession in the health care hierarchy. The AOM acted from the position there was a need to redress a sexist wrong which had excluded midwifery from the health system and part of that redress was fair compensation and positioning in the health care compensation hierarchy.

764. The AOM worked diligently to prepare for the meetings of the Joint Working Group and drew from its extensive knowledge base and experience.

765. The Joint Work Group met. All of those meetings were at the Health Station CHC. The CHC physicians at this Health Station were male predominant.

766. The Ministry in approximately May, 1993 hired an "equity" consultant, Robert Morton, to work with the Joint Group to do a compensation review to assist in arriving at a fair and equitable compensation level for midwives.[499] The July 6-23 meetings included Robert Morton.

767. Ms. Kilthei testified to how the process within the work group was informed by pay equity:

Q. What was your understanding of that as you went into those work group discussions of pay equity?

A. My understanding was that whenever you have a female-dominant profession, that pay equity needed to be addressed, and what I understood from conversations I had with Margaret Anne McHugh, who was the member for the implementation coordinator of the Women's Health Bureau, was that it was a given that this would need to be looked at….the Women's Health Bureau was looking at the position of women broadly, not just in midwifery, and that issues of gender equity in professions that were predominantly women, but also in, primarily, in the care that women received in the health care system.

Q. All right. And back on page 45, there was a reference to the Models of Practice and Payment Report, and it referred to, paragraph 157, midwives being paid equitably. Other times, there's the use of the term "equitable formula".

---

498 "Principles of funding midwifery in Ontario prepared by MOH Women's Health Bureau, January 1, 1992", Affidavit of Jane Kilthei, (Exhibit 1, Tab 76).

499 Affidavit of Jane Kilthei, (Exhibit 1) at paras. 220-225.

There's a reference to skill, education, working conditions. What did you understand was the measure that would be used to determine that equity?

Q. And in terms of -- you see in the affidavit of Mr. Morton that he talks about it wasn't kind of a technical job evaluation exercise. They didn't use some of the terms in the Pay Equity Act like job class or male comparator. Can you respond to that in terms of your understanding and experience of what happened in the work group?

A. Well, certainly, what I was given to understand was that we were doing a pay equity exercise.

Q. And you use the term "exercise". What does that mean?

A. Well, and again, because pay equity was issues all around us, I didn't think a lot about the specific terminology at the time, but as I think back on it now, I imagine like when Jim Shea used those words, that maybe in his mind it was something that was more of a work in progress than a full, formal pay equity analysis, but that's not something I thought at the time….we were also under a lot of time pressure to get everything in place for the 1st of January 1994, and so there were many things that were done at the first layer of how you would do it that were then worked on in more detail after the framework was set.[500]

768. As well, in May, 1993, the International Confederation of Midwives' conference was held in Vancouver, hosted by the Midwives Association of British Columbia. Kilthei presented a co-authored paper on the ongoing process of legislating, integrating and funding Ontario midwives which also informed the Working Group discussions.

769. At the meetings of the Joint Work Group on June 21 and 23, 1993 topics included budgetary funding and the development of an initial central transfer payment agency before devolution to local transfer pay agencies such as CHCs.

770. The Joint Working Group worked with updated information from Vicki Van Wagner's 1991 work, With Women: Community Midwifery which included her survey of 30 midwives about their caseload, conditions and hours of work. While Van Wagner had arrived at a figure of 45 hours per course of care, the AOM proposed 48.25 hours based on an updated detailed calculation of time given the midwifery model had developed by 1993. The AOM also recommended a full time caseload of 40 primary births and 40 secondary births.

771. At the above meeting, the AOM was advised that the Ministry had hired Robert Morton and the AOM after considering the matter agreed to work with him to carry out a pay equity exercise and compensation analysis. The AOM gave him contacts to interview.

---

[500] Testimony of Jane Kilthei, Transcript, September 15, 2017, at pp. 26 – 27.

772. The AOM also produced for the Group a document: “Midwives Compensation: Comparing Midwives with the CHC Primary Care Nurses and Physicians” [501]

(a) The “Cost Effectiveness” paper, for which Kilthei did the international literature review and lead the preparation of, showed that while midwifery was more labour intensive than the doctor/nurse/hospital model because of its continuity of care and 24/7 on call nature. It also saved costs. The research had showed, amongst other matters that it resulted in lower rates of interventions such as episiotomies, caesarian sections, and anaesthesia, shorter hospital stays, lower prematurity rates. As well, it showed the 4 year baccalaureate program, delivered in 3 calendar years with no summers off, also resulted in a very cost effective and specialized obstetric education.

(b) The “Midwives Compensation: Comparing Midwives with the CHC Primary Care Nurses and Physicians” document reviewed the compensation of the senior primary care nurse/nurse practitioner and also the CHC physician and proposed that there should be a pay range for midwives of between $56,000 to $80,000 in order to be above the senior nurse whose compensation was $42,000 to $56,000 and below the CHC physician who without the on call allowance of $5,000 had a wage grid for non-underserviced areas of $80,000 to $118,000.

773. Mr. Morton then took the Group at the July meetings noted above through a “pay equity exercise”. The term “pay equity exercise” is how the process was described to the AOM’s members in documentation prepared by Jane Kilthei and others and sent to them in October 1993 when they were asked to ratify the result.[502]

774. Ms. McHugh testified that Robert Morton was hired to evaluate what an equitable pay level would be.[503] Ms. Martha Forestell, Director of Women’s Bureau testified he was an equity consultant. The September, 1993 Cabinet submission refers to him as “compensation specialist”.

775. Mr. Morton testified that at the time of the report, regarding the Pay Equity Act he “understood it and, of course, I knew generally what it did and so, yes, absolutely” he was familiar with it. He stated that he mentioned the Pay Equity Act in Exhibit C “because it was a clear demarcation of the things that one would generally look at in a compensation exercise”. He recalled that the “International

501 "Midwives Compensation: Comparing Midwives with CHC Primary Care Nurses and Physicians" - Updated July 22, 1993, (July 22, 1993)", Affidavit of Jane Kilthei (Exhibit 1, Tab 108).

502 "Letter from AOM Funding Committee to AOM Voting Members re: Funding of Midwifery Services in Ontario attaching Ontario Midwifery Program Framework, Q&A about Midwifery Funding and Note re: Caseload and Working Conditions", Affidavit of Jane Kilthei (Exhibit 1, Tab 96) at p. 3.

503 Testimony of Margaret Anne McHugh, Transcript, February 21, 2017, at p. 23.

Labour Organization had standards that applied across types of legislation across countries and they looked at those sorts of things [skill, effort, responsibility, and working conditions]. So, pay equity was becoming significant at that time.[504]

776. Mr. Morton stated that his assignment from the MOHLTC was: "I was not to come up with a recommendation on that. It was clear that I was to provide information for the process so that the work group could come to a decision… About a fair and equitable compensation level, yes."[505] Mr. Morton also stated that he was aware that midwifery was an almost exclusively female profession, and aware that nurses were a very highly female profession, and that he "assumed it was correct" that physicians, at least traditionally, were a predominantly male occupation.[506]

777. The Morton report set out the terms that would be used to describe the type of compensation the work groups was seeking for midwives:

The terms 'appropriate' and 'fair' were defined at the beginning of the project in order to set the guiding principles for investigation, research and discussion.

"'Appropriate' was defined as setting a range that reflected the relative skill, effort, responsibility, and working conditions for midwives in comparison to related health care professions.

"'Fairness' was defined as a salary level which not only considered the above factors but also the general context in which compensation was to occur. This comparison was paramount since fairness can only be determined in relation to levels of pay for professionals working in the same economic market."[507]

778. Ms. Davey testified that in the Task Force recommended an analysis that looks at, essentially, skill, effort, responsibility and working conditions, and that this is what the MOHLTC did in the end. [508]

779. At the meeting on July 21, 1993, the AOM presented its July 13, 1993 document "How Much Should Midwives be Paid: The Issue of Equity".[509] The document cites the CHC physician's salary range at the time to be $56,000 to $85,000 and those on salary to be earning in the range of $ 85,000 to $123,000. The report cites Primary Care Nurses working at CHC's at the time to be earning between

---

504 Testimony of Robert Morton, Transcript, December 1, 2017, at p. 25 – 26.

505 Testimony of Robert Morton, Transcript, December 1, 2017, at p. 32 - 33.

506 Testimony of Robert Morton, Transcript, December 1, 2017, at p. 33 - 34.

507 Testimony of Remi Ejiwunmi, Transcript, September 29, 2017, at p. 155.

508 Testimony of Sue Davey, Transcript, October 20, 2017, at p. 123.

509 "AOM Principles of Funding and attached AOM document' How Much Should Midwives Be Paid? The Issue of Equity, (July 13, 1993)", Affidavit of Jane Kilthei (Exhibit 1, Tab 107).

$42,000 to $56,000. The report finds if the salary of a midwife was placed between the two groups then the range would be $56,000 to $85,000. The report proposed a salary range of $55,000 to $85,000 for midwives with an annual increase of $2,000 per year for active practice.

780. The AOM also discussed in the Joint Work Group its July 22, 1993 "Two Midwives at Each Birth" which detailed the need to have two midwives at the time of the birth itself for safety reasons, as required by the College of Midwives. Midwives are re-certified each year in neonatal resuscitation for this very reason. In 1993, nurses were not consistently required to be trained in neonatal resuscitation. Also, there are two persons to care for directly at the time of birth. The primary midwife generally cares for the mother and the secondary midwife for the baby. This is particularly important where there may be an emergency involving the mother and the baby at the same time. The secondary midwife comes just prior to the birth itself rather than at the start of labour where the primary midwife is the person responsible. Two midwives were found to lead to safer births. build skill and experience, and ensure continuity of care which is required by the CMO.

781. Part of the discussions of the Work Group also included the need to have an employment and compensation system which was structured to permit midwives to work part time as many were also working in other parts of the midwifery system such as being MEP faculty, with the AOM or with the College of Midwives. MEP faculty were required to be practising midwives.

782. As well, many midwives as women required maternity leaves and had family, child and elder care responsibilities which at times required them to work part time. As well, some midwives found the 24/7 on-call schedule so onerous that they needed to have a less than full time caseload. This was done through estimating full-time and part time equivalents of courses of care. Accordingly, many midwives remain active in the midwifery system even if not carrying a full time caseload.

783. The Work Group worked on various drafts of the Program Framework as they tried to work out the issues.

784. Relying upon the extensive knowledge of the AOM representatives with respect to the midwifery and the knowledge of Mr. Morton and Sue Davey and Jim Shea particularly with respect to the CHC positions, along with other interviews and documentation referred to in the Morton report, the parties came to a consensus which is reflected in the Morton report although Kilthei testified they did not participate in drafting of the report. Sue Davey had been an Executive Director in the Lawrence Heights CHC. Up to this time in the midwifery integration process, there had been a consensus in the reports noted above, that the compensation of a midwife should fall between a CHC physician and a senior primary care nurse/ nurse practitioner. As a result, these positions were the main focus of these comparison discussions to see what the appropriate equitable positioning

was. This included looking at the many data sources including extensive knowledge of the AOM, the midwives' above-noted Core Entry Level Competencies, and included but not limited to issues of baccalaureate education level, issues of work stress, the on call nature of midwifery work.

785. Throughout the discussions, efforts were made to include a pay equity lens in the compensation setting process by adopting an evidence based approach to making visible and valuing the work of midwives as they entered the health care system relative particularly to the CHC physician and the senior nurse/nurse practitioner.[510] The analysis of skill, effort, responsibility and working conditions ("SERW) which was the approach taken by the group. As well, at this time a decision had not been made as to whether some midwives might be employed as "employees" and therefore subject to the *Pay Equity Act* comparison of the SERW of their work and pay requirements. As noted above, SERW are the criteria used in Ontario's *Pay Equity* Act to compare male- and female-dominated work to ensure compensation free of systemic gender discrimination.[511]

786. Ontario physicians as a whole at that time were predominantly male (75.3% male)[512] and that included the CHC physicians at that time as testified to by Jane Kilthei, Vicki Van Wagner and Theresa Agnew who worked in a CHC at that time as a senior primary care nurse /nurse practitioner.

787. The Work Group considered the skill, effort, responsibility and working conditions of the entry-level midwife relative to the Community Health Centre ("CHC") salaried physician. It also compared the midwifery work to the work and pay CHC "senior primary care nurse/nurse practitioner". The pay for these two CHC positions were taken from the Ministry's provincial approved salary ranges for these positions.

788. The Ministry and Morton recognized in the Joint Work Group process the need to do a systematic analysis of the SERW of the midwifery work when setting the compensation structure for midwives.

789. During the July,1993 meetings of the Work Group, each side worked on a number of different drafts of the Program Framework document which ultimately took the agreed form set out in the September 1993 document. The July 21, 1993 draft prepared by the AOM proposed a range of $55,000 to $85,000 with 15 steps at $2,000 increments.[513]

---

510 "OMP Framework" Joint Book of Cabinet Documents (Exhibit 141, Tab 5) at pp. 2-3.

511 *Pay Equity Act*, R.S.O. 1990, c. P.7 (Exhibit 38).

512 "CIHI physician gender distribution charts (1978- 2014)", Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 21).

513 "AOM Principles of Funding and attached AOM document' How Much Should Midwives Be Paid? The Issue of Equity, (July 13, 1993)", Affidavit of Jane Kilthei (Exhibit 1, Tab 107) at p. 1.

790. When that proposal was discussed at the July 26, 1993 meeting at the CHB offices, Sue Davey responded that she could not “in good conscience” support a maximum rate of $85,000 for midwives. This is despite the fact that a range of $60,000 to $80,000 had been budgeted for the previous November. Davey had proposed a range of $55,000-$70,000. Kilthei responded that she could not in good conscience agree on behalf of midwives to the MOHLTC proposal. Subsequently, the annual compensation of $77,000.00 was agreed as the maximum midwifery rate and the steps were reduced to 12 (start and 11 steps). The purpose at that time of the lengthy set of steps was to recognize the extensive experience of the existing practising midwives. In addition, the Group came to an agreement that the secondary midwife required by the CMO would be paid.

791. The above-noted compensation grid meant that midwives would be paid 90% of the lowest step of the CHC Physician non-underserviced salary grid (which was $80,000)and approximately 65% of the maximum rate of that grid. The AOM was not advised at that time there was a higher rural underserviced grid.

792. Based on the above discussions and agreement, the MOHLTC agreed compensation on a salary basis with a salary range starting at $55,000 and extending up to $77,000, and that progression through this range would be based on 11 annual increments of $2,000.

G. The Morton Report

793. The Morton report, dated July 1993, used a modified rough pay equity analysis, along with other factors to initially set the midwives’ compensation in a way which reflected their skills, effort, responsibilities and working conditions (based on their entry-level competencies) relative to male-dominated and other professional health-care work. As Morton noted in his report, his purpose was to assist the Working Group to arrive at its own conclusions.

794. The Morton report summarized the "method to establish the compensation level " as follows:

An endeavour such as setting a salary range for a new profession is a matter of informed judgement. The Consultants sought to inform the judgements to be made through systematic and careful research into how the profession of midwifery compared to related health professions with respect to the dimensions of skill, effort, responsibility and working conditions. Toward this end, they surveyed approximately 25 consumers, midwives, nurses, physicians and educators, by telephone, to establish perceived similarities and differences between related jobs and that of Midwifery. Information regarding the relative skill, effort, responsibility and working conditions gained from this research, as well as a proposed framework for comparing jobs, was brought to the Work Group for review, discussion and confirmation in an initial working session. General agreement was reached, by the Work Group, that the system would

provide a sound method for examining the relationship between the job of the midwife and those of comparator professions. In order to further assess the comparison method, the consultants sought the perspectives of people in other health professions to confirm its validity. This resulted in what the consultants considered to be a fair and objective outcome in terms of the process and content of the exercise.

During a second working session, the consultants presented a refined set of rating scales which emerged from discussions in the first session. The process included defining the essential elements of each of the key factors such as education, breadth of knowledge and responsibility in decision-making. In addition, the consultants presented a comparison of "Authorized Acts" (Appendix A), a comparison of job requirements (Appendix C) based on job descriptions for a primary care nurse and a family physician in a Community Health Clinic and a list of core competencies for midwives (Appendix B). These comparisons were further informed by considering relevant dimensions of other related professions such as psychology and social work. The outcome of this session was agreement on the relative positioning of midwifery in relation to primary care nurses and family practitioners in a Community Health Clinic.

A third working session aimed at deriving a salary range for midwives was then undertaken. The consultants presented current salary data (Appendix D) which they had collected in relation to professions in the health and social service fields. This enabled the Work Group to consider the "market value" of the various professions. Again, the primary comparisons were with primary care nurses and family physicians in a Community Health Clinic, but other, such as psychology, dentistry and pharmacy were considered. The group then worked toward a preliminary decision on a salary range for midwives in Ontario.

At a fourth and final working session, the Work Group revisited issues and reached agreement on the above noted salary range.[514]

795. The report also included consideration of a market analysis as well as the results of discussions between Ministry and the AOM.

796. With respect to the report:

(a) While midwives serviced all of the areas covered by the CHCs, the report did not address the issue of whether midwives should be paid more for working in the “underserviced” areas although this warranted more pay for the CHC physicians. The Morton report used the pay grid of $80,000 to $118,000 salary grid used to compensate CHC physicians in non-underserviced areas and also used the entry step on that grid ($80,000)

514 "Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report" Affidavit of Moshe Greengarten (Exhibit 124 , Tab 4) at pp. 2-3.

rather than the maximum job rate of $118,000. The higher pay grid for underserviced areas ranged from $117,766 to $135,830.

(b) In recognition of the need to recruit physicians to underserviced areas, the CHC provincial salary schedule provided for a separate higher grid for underserviced areas which were all the areas other than the GTA, Hamilton, London, Windsor**.** Some centres with a satellite location designated as “underserviced” will have physicians on two separate grids.[515]

(c) The $80,000 to $118,000 figures did not include the CHC physicians' on-call compensation of $5453. As well, it did not address the fact that CHC physicians were generally started at the maximum rate rather than the minimum rate as the CHCs were funded for physicians to be paid at the maximum rate.[516]

(d) The report also did not address the issue of benefits. These were later set at 16% of the salary in discussions that took place between the CHB and AOM in the fall of 1993.

(e) As the midwives were not yet working in their new regulated practice group setting, the Morton job comparison analysis left a "?" for what midwives’ responsibilities were for "supervision" and "administration" while providing credit for those job features to the CHC physician and CHC primary care nurse.

(f) The report also did not state what consideration was given to the fact that the midwives worked for approximately 44 hours per week and the CHC nurse and physician had a 35-hour work week.[517]

797. During this process there continued to be discussions about the proper employment status for the midwives. It was finally decided that the midwives should at least initially be in a contract relationship rather than a traditional employee model. This model was consistent with the principles that the funding should be driven by the model of care and would best meet the needs of women by providing continuity, informed choice and choice of birthplace. The AOM understood that "employee" arrangements might still be considered on devolution.

---

515 "Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report" Affidavit of Moshe Greengarten (Exhibit 124 , Tab 4) at pp. 2-3.

516 "MOHLTC Handbook for Developing A Community Health Centre: Phase II: Needs Assessment & Proposal Development. Association of Ontario Health Centres, Rev. September 2000 and attached Appendix Community Health Centre Program Approved Salary Ranges" Affidavit of Jane Kilthei (Exhibit 1, Tab 112).

517 "Hay Group, “Association of Ontario Midwives: Compensation Review February, 2004”, Affidavit of Moshe Greengarten (Exhibit 123, Tab 5) at p. 6.

798. The employment and compensation system for midwives was structured to permit midwives to work part time as many were also working in other parts of the midwifery system such as being MEP faculty, with the AOM or with the College of Midwives. This was done through estimating part time equivalents based on 80 courses of care as a full time workload.

799. The Joint Funding Work Group came to a consensus with respect to the document, September, 1993 Ontario Midwifery Program Framework.

H. MOHLTC Refusal to Describe Process as a Pay Equity Exercise

800. Dr. Ivy Bourgeault testified to how she gathered information for her thesis and caught the description and understanding of the work of the funding work group shortly after they finished their work. In 1995 she interviewed Jane Kilthei, Jim Shea, Margaret Anne McHugh, and two Ministers and others around the funding discussion[518]. She also sourced newspaper articles of the time. Her thesis reflects that she heard Robert Morton described as a pay equity consultant[519], and "that a pay equity exercise was undertaken. So that is the language that I used in my thesis. It reflects the language that I heard and was corroborated by a number of sources."[520]

801. However, Ms. Porter also testified that she was not familiar with the framework document that was negotiated by the government and the Association of Ontario Midwives that's dated September 1993.[521]

802. And yet, Ms. Porter agreed with the proposition that the of pay equity issue "had been resolved before it went to the Deputy Minister for approval in the sense that discussions had taken place, and the midwives were not raising any concerns that the proposed compensation would be inequitable and the issue was just resolved before it went to the Deputy Minister. Ms. Porter said:

> *It seemed resolved. No one, including IRCM or NC or AOM or Karyn, Dr. Kaufman, or any of the constituents or -- and frankly, the Minister's office was full of wonderful feminists with incredible background in the community. No one anywhere raised questions. Everyone seemed content with the process, and just the absolute miracle at the time this was going to happen, which we were very proud of".*[522]

803. Ms. Porter stated that "simply getting the profession in the field resolved issues of equity and gender equity and practice equity. I mean, it was against all opposition

---

518 Testimony of Ivy Bourgeault, Transcript, March 21, 2017, at p. 218.

519 Testimony of Ivy Bourgeault, Transcript, March 21, 2017, at pp. 220 – 221.

520 Testimony of Ivy Bourgeault, Transcript, March 21, 2017, at p. 37.

521 Testimony of Jodey Porter, Transcript, February 21, 2017, at p. 200.

522 Testimony of Jodey Porter, Transcript, February 21, 2017, at pp.216 – 217.

and there was opposition not just from doctors, but from all across the health care system."[523]

804. Ms. Porter agreed that it is possible that this issue was not the subject of significant discussion or even any discussion at your level or at the Deputy Minister level because efforts had been made and a kind of pay equity had been achieved in how the funding was conceived of; and that If pay equity had not been achieved or equitable compensation had not been achieved or there was an enormous gap between some male-dominated profession and midwives, you might have heard from midwives on that issue and that would continue to be the subject of some debate. To this proposition, Ms. Porter said: "Yeah, it wouldn't have gone out the front door of the Ministry. It simply wouldn't in that environment."[524]

805. Ms. Porter was unable to provide much detail to how women were protected from undervaluation, if indeed, the 1993 process was not a rough pay equity exercise:

Q. And what system, policies or practices did you have in place to make sure that when it was valued, there was no undervaluation based on it being women performing midwifery work?

A. A number of people were involved in the process, and I'm sure their expertise, if inadequate, I'm sure they looked for people outside the Ministry. I really do not know what the system was…There wasn't a system simply to look at undervaluation…There wasn't a person who would be valuing the work. It was a conjoint process that started with the development of a policy framework, began with Karyn Kaufman, that we got expertise from across my ADM group, that then proceeded for approval, that then proceeded through decision-making, that then proceeded to a payment reference group, and proceeded out the door.…The payment reference group was the group under the aegis of Michael Ennis. That was the launch pad, the launching group for valuation and implementation.[525]

806. Ms. Kilroy recalled as a member that she was told by the AOM leadership '

there was a pay equity lens brought to this decision-making, and that they were very aware that this pay equity legislation was relatively new in Ontario. They were proud of it. They were establishing a new, clearly predominantly -- dramatically predominant female profession, and there was a shared desire not to create a situation where this profession would be marginalized and would be less valued than it ought to be. So, that lens was brought to the discussions and was brought to bear.

---

523 Testimony of Jodey Porter, Transcript, February 21, 2017, at p. 217.

524 Testimony of Jodey Porter, Transcript, February 21, 2017, at pp. 217 - 218.

525 Testimony of Jodey Porter, Transcript, February 21, 2017, at p. 203.

807. Ms. Kilroy understood that the pay equity lens was applied by "using the tools that pay equity analysis actually used which we saw in the Morton report that they talked about the scope and the responsibilities and working conditions and so on… also it was about bringing a political commitment basically to the work that was being done to establish midwifery in the province."[526]

I still carried this belief that there was a commitment to pay equity principles and a pay equity lens from the Ministry's side. We had been told that by our leadership… This was looked at with a pay equity lens and we believed that to be the case.[527]

808. The midwives also thought the Morton report would assure that their compensation would be treated equitably, and reviewed on a regular basis, with COLA as required:

we had gone through the best possible version of a pay equity exercise we could do given that we were not yet integrated into the health care system, and that our entry pay had had pay equity considerations apply. And so what I imagined was that somewhere in the range of 1996/97 was when this would likely be looked at, and that that was the government's responsibility.[528]

The AOM expected that pay equity would be part of the process of determining the compensation of the midwife relative to appropriate comparators and that the process would be ongoing. [529]

As Ms. Kilthei summed up her testimony about the midwives understanding:

Q. And it does not include any reference to an obligation on the Ministry of Health to periodically reassess compensation levels using pay equity principles?

A. I agree. And our assumption was that the government was clear on their obligation and it didn't -- did not need to be included; apparently I was wrong.[530]

809. As well, when midwives were asked to ratify the September, 1993 OMP Framework document in October, 1993, they were told the process used to arrive at the result was a "pay equity exercise."

810. Hay Group principal Mr. Greengarten testified that he used the Morton report as part of we preparation and research for the AOM's compensation review project and came to the conclusion

---

526 Testimony of Katrina Kilroy, Transcript, October 6, 2017, at pp. 9 – 10.

527 Testimony of Katrina Kilroy, Transcript, October 6, 2017, at p. 17.

528 Testimony of Jane Kilthei, Transcript, September 15, 2017, at p. 97.

529 Testimony of Jane Kilthei, Transcript, September 15, 2017, at p. 149.

530 Testimony of Jane Kilthei, Transcript, September 15, 2017, at p. 125.

That the Morton report was reasonable and produced a credible recommendation or results, I should say, in terms of setting out key principles for compensating Ontario midwives, and in particular, set out what we believed, based on our reading of the Morton report, set out a reasonable, internal, or let's say equity structure for the midwives as compared to other health care professionals. [531]

811. Greengarten reiterated this in his testimony[532] [533] and determined that Ontario midwives should fall between the pay levels of a family physician and a nurse practitioner.[534] He stated that "it is a methodology that is in common use by compensation people, employees or consultants."[535]

812. Ms. Davey's testimony on balance is evasive in denying the pay equity exercise approach during the Joint Work Group process. She also did not arrive at the Ministry until the spring of 1993. When the Morton document Guide to Primary Position Comparisons which said stated "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", Ms. Davey stated that this document was discussed with the group, and the reference to the Pay Equity Act was also discussed in the joint work group: "The reference to the Pay Equity Act here is talking about, in the Pay Equity Act, they do job evaluation and they use those factors." When asked if it informed the Ministry's decision-making in the joint work group, Ms. Davey replied:

A. I don't believe we brought this before the committee, but certainly, we would have all been aware of it and we would have been bringing ideas from all sorts of places, but not to say, "Okay, now we're going to follow this particular road." There was no document like that that we took before the committee.

Q. And the idea about it being a pay equity process somehow left the road between December and May. Is that your evidence?

A. I think my evidence would be I'm not sure that a pay equity process was ever contemplated. I don't know that it left the road because I don't know what she meant.[536] *…I don't know what Margaret Anne meant by pay equity, by pay equity in that, in that particular document, and so I don't know if the pay equity process was ever contemplated by anyone at the Ministry. I don't know that.*[537]

---

531 Testimony of Moshe Greengarten, Transcript, October 13, 2017, at p.14.

532 Testimony of Moshe Greengarten, Transcript, October 13, 2017, at p. 19 - 20.

533 Testimony of Moshe Greengarten, Transcript, October 13, 2017, at p. 165.

534 Testimony of Moshe Greengarten, Transcript, October 13, 2017, at p.20.

535 Testimony of Moshe Greengarten, Transcript, October 13, 2017, at p. 191.

536 Testimony of Sue Davey, Transcript, October 20, 2017, at p. 219.

537 Testimony of Sue Davey, Transcript, October 20, 2017, at p. 219.

I. Joint Work Group Morton Process a Rough Pay Equity Exercise

813. The MOHLTC fully participated and embraced the methodology and outcomes of the Joint Work Group consensus process reflected in the Morton report and used that process to relatively position their compensation and funding of midwifery services in the existing and gendered health care funding system in accordance with that process.

814. At that time, the Government, through its 1986 *Green Paper on Pay Equity* and legislation and implementation of the Pay Equity Act for its own employees and the public sector employees it funded, was well aware of the research available that demonstrated that women were discriminated against with respect to pay including Dr. Pat Armstrong's report for the Pay Equity Commission on the predominantly female health care sector. [538]

815. The parameters for determining the relative positioning of midwives was informed by a number of policy documents in evidence, starting with the Task Force on the Implementation of Midwifery and the Interim Regulatory Council of Midwives document dated June 19, 1992, "Interim Regulatory Council on Midwifery Models of Practice and Payment Committee Report and Recommendations"**.** Margaret Anne McHugh testified that this document was treated very seriously as advice."[539] McHugh stated she inherited principles of funding from Task Force and IRCM and that Jodey Porter had approved these principles.[540] The IRCM stated that it is important that midwives be fairly paid in keeping with their role as primary care providers and called for their relative positioning between primary care nurses and family physicians. [541]

J. September 1993 Ontario Midwifery Program Framework And Cabinet Decision

1. OMP Framework

2. Introduction

816. The September 1993 Ontario Midwifery Program Framework formed the basis of the government's "Ontario Midwifery Program" announced along with public funding on October 1, 1993.[542] The Framework was approved by the AOM after being ratified by its members in October, 1993.

---

538 Green Paper on Pay Equity, (Exhibit 137).

539 Testimony of Margaret Ann McHugh, Transcript, February 21, 2017, at p. 10.

540 Testimony of Margaret Ann McHugh, Transcript, February 21, 2017, at p. 55.

541 Testimony of Jane Kilthei, Transcript, September 15, 2017, at p. 48.

542 "OMP Framework" Joint Book of Cabinet Documents (Exhibit 141, Tab 5).

817. This resulted in the Ministry setting the compensation for midwifery provided in its Ontario Midwifery Program at a salary scale that was more than the female-dominated primary care nurse practitioner and less than the CHC physician. The top range of midwifery salary was set at approximately 63% of the maximum pay of the CHC physician for non-underserviced areas ($118,000 plus on-call fee of $5323) and 82% of the lowest paid CHC physician ($80,000 plus on-call fee of $5323).[543]

818. This salary scale represented a very rough start toward pay equity using a proportional value method, which came into force as a method under the *Pay Equity Act* in January 1, 1993. It resulted in the midwives receiving a significant pay equity adjustment from their pre-regulation compensation.

819. Given the importance of this Program Framework which has been relied upon by the AOM and the Government in subsequent funding discussions, selected key text of that document is reproduced below:

The main features of the Ontario midwifery model of practice, which involves providing primary care maternity services in the community, (see Appendix I - The Midwifery Model of Practice) are as follows:

Continuity of Care
Informed Choice
Choice of Birth Place

The Ontario Midwifery Program is designed to be supportive of this model of practice and to be consistent with the standards of practice as developed by the College.

Health Reform in Ontario

The Ontario health reform objectives have also influenced the development of this program. The Ministry's efforts to introduce greater accountability and local decision-making to the health system and ensure more significant consumer participation in the management and direction of programs is well supported by the directions proposed for the Ontario Midwifery Program.

During the 1980's, large numbers of both family physicians and obstetrician / gynaecologists stopped practising obstetrics. A survey of family medicine residents at McMaster University in 1988 showed only 20% of newly graduated family physicians starting practices which included obstetrics. With fewer family practitioners providing obstetrical services for low-risk pregnancies, higher cost

543 "Hay Group, “Association of Ontario Midwives: Compensation Review February, 2004”, Affidavit of Moshe Greengarten (Exhibit 123, Tab 5) at p. 6. The higher grid for the CHC physician in 1993 who worked in underserviced areas was $117,766 to $135,830 on top of which is added the on-call allowance. The lower grid was $80,295 to $117,766 before adding in the on-call allowance.

specialists are being used more often and pregnancy and birth have become increasingly illness and intervention oriented. The introduction of midwifery funding in Ontario will help to reorient care for low-risk pregnancy and birth by supporting a community-based approach which supports greater consumer involvement.

Research has shown that midwifery care achieves improved health outcomes for both the child and the mother (e.g. fewer low-birthweight babies, lower C-section rate). Midwives "also have lower associated costs (e.g. lab tests, bed-day costs) as a result of a lower intervention rate and a de-emphasis of the high-tech approach. There is also a lower rate of pharmaceutical use.

As the health system attempts to emphasize wellness and health maintenance, midwifery services are well positioned to support these efforts in the area of maternal and child health.

Consumers have been at the forefront of the definition of the model of practice and have been instrumental in urging government action in the areas of regulation and funding. This consumer involvement fits well with the health reform concept of continuous quality improvement Quality of service, in this concept, is defined not simply by the profession delivering the service, but more importantly by the consumers of the service.

The group practice model is seen as one which works well for midwives and their clients. It helps to ensure that the model of practice is realized and assists the individual midwives in providing the highest quality of care. This is achieved through peer review, peer consultation and the shared-care approach.

TPAs will either contract for services with midwifery practice groups or employ midwives to provide services within a practice group. The arrangements will depend on local conditions and the desires of the TPA and the midwives wishing to practice in the area. Local arrangements will have to conform with established requirements of the Ontario Midwifery Program, such as the levels of compensation for the midwives, appropriate expenses and the model of practice. In addition, the arrangements will have to ensure that the essential local management functions are in place (e.g. monitoring of service levels and access).

Each TPA will enter into a funding contract with the Community Health Branch. The contract will be consistent with the framework as outlined in this report and will stipulate the service delivery expectations, financial requirements and level of funding. While funding is expected to continue from year-to-year, the contracts will be annual.

The Ministry will fund the central organization to provide midwifery programs. The central organization will, in co-operation with district health councils and the Ministry of Health, identify appropriate TPAs who may be interested in providing

a midwifery program for their area. It will then assist a midwifery practice group in making arrangements (service contract or employment) with the local TPA and when everything is in place (including Ministry approval) the Ministry will redirect funding for that midwifery program from the central organization directly to the local TPA.

HUMAN RESOURCES AND FUNDING

……

A transfer payment agency with responsibility to deliver a midwifery program will employ midwives or enter into a contract with a practice group to provide midwifery services to women and their families. Th.is contractual or employment arrangement will include caseload expectations which will take into consideration the particular circumstances related to providing midwifery services in that area.

In a typical practice group each midwife working full time will provide care, either as primary or secondary care-giver, for 80 pregnant women and their newborn infants. Since midwives generally work within a shared-care approach, each midwife will act as the primary care-giver, providing a complete course of care throughout pregnancy, labour and birth, to 6 week postpartum for 40 women and their newborns. Additionally, each midwife will be the secondary care-giver to another 40 women and their new born infants. Transfer payment agencies will be able to use these figures to plan for the number of women and their families to whom it can make the midwifery program available.

Not all midwifery practices, however, will be typical. There are a variety of factors which could have an impact on the precise number of courses of care which could be provided in a particular year. Special consideration of these factors will be required in planning programs and developing contractual and employment arrangements. The factors which have been identified may increase or decrease the number of courses of care from the number provided in the typical practice as noted above.

Those identified factors related to the client population which may have an impact on caseload are as follows:

> *age, previous caesarean section, disability, socioeconomic status, language and culture, and geography.*

Other factors which may have an impact on practice caseloads are catchment area and participation in related activities (e.g. requirements for integration into the health system).

a. *Compensation of Midwives*

Midwives will be compensated on a salary basis. This approach to compensation is best able to support the model of practice and is most compatible with the community health approach to program and service delivery.

The salary range will be $55,000 to $77,000, subject to cost-of-living adjustments as determined from time to time by the Ministry of Health. All transfer payment agencies receiving funds from the Ontario Midwifery Program will be required to contract or employ midwives in accordance with this salary range and the following terms for its application:

- *The range will have 12 steps and each step will represent an equal fixed dollar increment. (i.e. The range of $55,000 to $77,000 will have eleven $2,000 increments.)*

- *The first step is considered to be the entry level for a newly registered midwife with experience of less than one year's active practice.*

- *Progress through the range will occur with the Increase in the number of years of active practice. Each step represents one year of active practice.*

- *The Initial group of registrants will be placed on the range according to their level of experience. This will be determined in accordance with the definition of active practice used by the Michener Institute in determining the level of experience for the Pre-registration Program.*

- *Midwives entering the Ontario health system from other jurisdictions will be placed on the range In accordance with a determination of their years of active practice (or its equivalency) In a model of practice similar to that of Ontario*

b. *Operating Expenses*

Midwifery Services Expenses

Operating expenses of the midwifery practice group related to the provision of midwifery services determined to be acceptable for funding will be Included in the funding arrangements. Although specific details regarding which expenses will be included have still to be worked out, it is assumed that they will be similar to those details worked out in the Community Health Centre Program. For example, expenses related to premises, equipment, supplies, communications and travel are regarded as acceptable expenses. There may be some variation from other programs in the Ministry to accommodate the uniqueness of the Ontario Midwifery Program.

K. Cabinet Program Framework

820. Ms. McHugh did not raise concerns that the September, 1993 Cabinet submission did not contain the gender impact statements:

Because it said things like appropriate -- you know, that they used an outside compensation specialist "to ensure that an appropriate and fair compensation level was established." That was based and "should reflect the relative skill, effort, responsibility, and working conditions for midwives..." That to me was essentially pay equity. It was establishing that it would be fair, so I had no concerns about that. I mean, that's often the description of pay equity, to do, to evaluate relative skill, effort, responsibility and working conditions, maybe education in addition.[544]

L. Ratification by AOM

821. Following the Cabinet's approval of the Program Framework and the public announcement of the Framework by the Minister of Health on October 1, 1993, the AOM set to work on getting the Program Framework ratified by its members. Jane Kilthei and Eileen Hutton developed supporting materials which were forwarded in October, 1993 to AOM members to explain the process leading up to the development of the Program Framework and the setting of the funding and compensation terms. These materials referred to the “pay equity exercise” which was undertaken jointly by the AOM and the MOHLTC facilitated by Mr. Morton which resulted in the comparison of the midwife to the CHC physician and the CHC primary care nurse/nurse practitioner. These documents formed the basis on which the AOM members ratified the Program Framework.

M. Developing the Ontario Midwifery Program Guidelines and initial LMCO Funding Contract

1. Introduction

822. Subsequent to the Program Framework, the AOM continued to negotiate with the Ministry. During the period after September, 1993, the Joint Funding Working Group and particularly Jane Kilthei working with Jim Shea and Sue Davey also jointly worked on negotiating the Ontario Midwifery Program Guidelines working through a number of drafts. This Group also worked on developing benefits, cost of practice and compensation variables.

2. Fall, 1993 Negotiations for Programme Guidelines and Contract Provisions

823. The basic structure for the delivery of midwifery services was to be carried out by midwives in practice groups. Each practice group enters into a contract with a Ministry-appointed TPA. This contract sets out the compensation to be paid to

---

544 Testimony of Margaret Anne McHugh, Transcript, February 21, 2017, at p. 72.

midwives as directed by the MOHLTC in its contract with the TPA. The Ministry funds the compensation of midwives through the TPA.

824. Subsequent to the September, 1993 Framework, the AOM was advised that the funding available for the new midwifery system was less than the figure which the MOH representatives had advised in the Funding Work Group discussions leading up to the Program Framework.

825. The Lebel Midwifery Care Organization(LMCO) (named after the midwife who attended the birth of the Dionne Quintuplets), was established in October, 1993 as the interim central transfer payment organization with funding directly from the Community Health Branch of the Ministry of Health.[545] LMCO was to act as a central transfer payment agency until the program could be devolved to community-based TPAs which was targeted by September, 1993 Program Framework for 1997.

826. Midwifery compensation was described in the LMCO contract as a “salary”.

827. Midwives were characterized at this time as “dependent contractors:”[546] The Program Framework provided that transfer payment agencies would “contract or employ” midwives in their practice groups based on the designated salary. The AOM’s 1994 Guide states:

> *“Midwives are dependent contractors. They are contractors for service in terms of controlling their own business but they are dependent on one source for funding of their midwifery activities (i.e., the Ontario Midwifery Program) and are therefore dependent economically.”*[547]

828. As a result of discussions, it was decided by the MOHLTC that the midwives would receive benefits in the amount of 16% of their "salary".

829. The AOM developed a benefits package for midwives that recognized the unique elements of the Ontario Midwifery Program. As they were “dependent contractors” midwives were not covered by Unemployment Insurance Benefits or the Employer Health Tax.

830. The AOM established an AOM Benefits Trust Fund in late 1993. All benefits were then disbursed from the Trust Fund. The LMCO then disburses to the Trust Fund the 16% of midwives’ salaries budgeted for benefits. Initially, effective January 1,

---

545 "LMCO Factsheet re: Background Information on Midwifery Funding, (January 1, 1994)", Affidavit of Jane Kilthei, (Exhibit 1, Tab 121).

546 "Midwifery Practice Financial & Business Manual, 1995", Joint Book of Legislation, CMO Standards, and AOM Guidelines at L87.

547 "Midwifery Practice Financial & Business Manual, 1995", Joint Book of Legislation, CMO Standards, and AOM Guidelines at L87.

1994, the benefits were a group health plan, group RRSP and a maternity/short term disability self-insurance plan.[548]

3. Initial LMCO Contract

831. The AOM, MOH and LMCO worked on creating the initial LMCO funding contract. The AOM's Jane Kilthei worked with the LMCO's initial Executive Director, Betty Dondertman in early 1994 to work on the budgeting and operational issues. The 1994 LMCO Funding contract between LMCO and the Ministry set out the compensation to be paid to midwives, which was then reflected in the funding agreement between the LMCO and the “practice group". That agreement continued in place until a new contract was implemented in 2000 when devolution actually took place.

832. The LMCO/Midwifery Practice Group agreement provided that:

(a) The LMCO will pay to the practice group as funding compensation for midwifery services during each fiscal period a range of remuneration that is a salary starting at $55,000 with a maximum rate of $77,000.

(b) "The rate of compensation shall increase by a fixed amount ($2,000) after each year of full time service completed by the midwife, to the maximum rate in the Table."

(c) "In keeping with the principles of the social contract, if the amount payable for a midwife in 1994/1995 is projected to be greater than $30,000 the amount payable in that fiscal year will be reduced by 4.4%; but if the reduction results in the amount payable for that midwife in that fiscal year being less than $30,000, the amount payable will be $30,000."

(d) Funding to the midwifery program is divided into "compensation," "operating," "special operating" and "non-recurring." Compensation is only paid to practice groups for approved Ministry midwifery positions. Professional liability insurance was an operating expense. The only matters covered by “compensation” was the salary.

(e) The LMCO will also pay an amount equal to 16% of the amounts paid for "compensation" for the cost of a benefit package.[549]

---

548 "Midwifery Services of York Draft Plan re: The AOM Benefits Package December 28, 1993 Approved by the AOM Executive, (December 28, 1993)", Affidavit of Jane Kilthei, (Exhibit 1, Tab 127).

549 "Funding Agreement between Lebel Midwifery Care Organization of Ontario and Midwifery Practice Group, (January 1, 1994)", Affidavit of Jane Kilthei, (Exhibit 1, Tab 133) – see article 3.10 re: benefits.

833. The LMCO working with the AOM and the practice groups came to a decision as to where each of the midwives were placed on the range based on their experience level and the designation of whether they were full time or part time. The system provided that midwives were based on the percentage full time as well as years of experience.

834. At the time of regulation, the LMCO contract did not have any specific provisions to address the unique concerns of rural and remote midwives. Such provisions were not enacted until the 2008 contract (with the exception of the caseload variable for travel.)

835. As of January 1994, midwifery became a fully regulated profession and a government-controlled and funded service for Ontario women.

836. The LMCO's summary of the status of midwifery at the time of regulation is as follows:

(a) *The College of Midwives' standards require two midwives at a birth, and most midwives organize their work in a shared care arrangement within a practice group. Funding for midwifery services is flowed to the practice group, not to individual midwives.*

(b) *Funding to a midwifery practice group begins when the practice enters into a contract with LMCO (or, in the future, another agency) to provide midwifery services in a Ministry-approved catchment area. The practice group is funded for the set-up costs, operating expenses (rent, travel, etc.) and individual compensation (not salary, as midwives are not employees).*

(c) *The compensation level of a midwife is between that of a senior salaried nurse and a family physician and reflects the level of responsibility as a primary care provider and the demanding nature of a midwife's work.*

(d) *Pregnant women can book directly with a midwife; a physician's referral is not required. A woman who chooses midwifery care for her pregnancy, delivery and postpartum care will not normally see a physician; the midwife is the primary care provider.*

(e) *In line with the Ontario model of midwifery practice, midwives are required to be on call 24 hours a day, seven days a week. Usually a client will be cared for by two midwives in a shared-care arrangement and in no situation will a client see more than four midwives during her course of care. A great deal of information-sharing takes place during clinical appointments, which last approximately 45 minutes.*

(f) *Midwives provide comprehensive postpartum care to women and their newborns; they make several home visits in the days and weeks following the birth.*[550]

(g) *As of proclamation, there were 68 midwives in 21 practice groups serving Ontario women in specific government-designated catchment areas from Kingston to Niagara, as well as the communities of the Grey-Simcoe area, Guelph, Huntsville and the surrounding area, Kitchener-Waterloo, London, North Bay and the surrounding area, Ottawa, Peterborough, Sarnia, Sudbury and Thunder Bay. Each midwife working full time provides care in a shared-care arrangement to 80 women and their newborns throughout pregnancy, birth and the postpartum period on an annual basis. A midwifery practice made up of four midwives provides care to 160 women each year.*[551]

(h) *For many years to come, the demand for midwifery services will far exceed the availability.*[552]

837. Article 6 of the LMCO contract provided that midwives were not able to accept money for midwifery services.[553] CHC physicians were able to bill OHIP for insured services provided outside the CHC – such as in a walk in clinic.

PART 26: 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

838. 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

---

550 "LMCO Factsheet re: Background Information on Midwifery Funding, (January 1, 1994)", Affidavit of Jane Kilthei, (Exhibit 1, Tab 121) at p. 2.

551 "LMCO Factsheet re: Background Information on Midwifery Funding, (January 1, 1994)", Affidavit of Jane Kilthei, (Exhibit 1, Tab 121) at p. 2.

552 "LMCO Factsheet re: Background Information on Midwifery Funding, (January 1, 1994)", Affidavit of Jane Kilthei, (Exhibit 1, Tab 121) at p. 2.

553 Midwives were permitted to charge for teaching childbirth education classes.

continue to operation in some measure in Ontario and devalue the work and pay of midwives.

839. This history is highlighted as contextual background in the AOM expert reports of Mr. Durber, Dr. Armstrong and Dr. Bourgeault and in the report of Dr. Candace Johnson's report. The other MOHLTC expert reports, the MOHLTC pleadings and witness statements ignore this gendered history of midwifery disadvantage and pay discrimination.

840. 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.

841. 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 the AOM Overview Summary of Evidence attached as Appendix 5.

842. 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.

843. 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.

844. 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.

845. 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.

846. 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.

847. 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.

848. 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 85.7% male and Ontario physicians generally were 88.1%.[554] 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.

849. 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.

850. 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.

851. 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.

852. The complainant midwives had their employment structured by the MOHLTC initially as salaried "dependent contractors". 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

554 "CIHI physician gender distribution charts (1978- 2014)", Affidavit of Vicki Van Wagner, (Exhibit 22, Tab 21).

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.

Vulnerability and Control by MOHLTC

853. 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.

854. Contrary to the broad control and bargaining power afforded by the MOHLTC to the male predominant physician profession, the Ministry retains overarching control of the significantly smaller, female-dominated midwifery profession, including with respect to the structure and terms of compensation and the timing, content and parameters of any discussions/negotiations. The Program Framework, contractual agreements, combined with the provisions of the *Midwifery Act, 1991* and relevant provisions of the *RHPA, 1991,* the control of the funding for education placements and other budgetary and program policies establish this high degree of government control over the practice of midwifery.

855. The Ministry controls the size of the midwifery profession, where midwives practise throughout the province, he size of their practice and their ability to withdraw their services as a result of their professional obligations of care and the exigencies of caring for women during pregnancy and childbirth.[555] Midwives have no ability to withdraw services without breaching CMO standards and jeopardizing the care of women and their newborns. Nor are midwives afforded the contractual right to be included in discussions regarding future directions for maternal newborn care as are physicians under OMA agreements.[556]

856. The midwifery practice group is constrained in the amount of clients that midwives can take on, since caseload is preapproved by the MOHLTC. In

555 "Midwifery Funding (For Internal Use Only) Final: March 21, 1996, prepared by Bonnie Heath, Co-Ordinator, OMP, Community Health Branch" Government Documents to put to Sue Davey, Vol. I (Exhibit 142, Tab 19) at p. 9; "Issue Note: What is the status of funded midwifery services in Ontario? Prepared by Wendy Katherine, approved by Sue Davey" Government Documents to put to Sue Davey, Vol. II (Exhibit 143, Tab 33) at p. 4; Mb20 Report Back Midwifery Program Briefing Note, with Communications Plan attached to Midwifery Request for Release from Holdback to Fund More Midwives" Affidavit of Sue Davey (Exhibit 135, Tab 167).

556 "Agreement OMA-MOH 2000-2004" Joint Book of Final Agreements (Exhibit 144, Tab 4) at Appendix A.

contrast, a fee-for-service physician is not constrained in the number of patient they can take on, nor the kinds of service they can bill for. While a fee-for-service physician may "set up a shingle" anywhere in the province, a midwife may not practice unless she joins a practice group. The availability and size of practice group placements however, is controlled by the Ministry, who can approve or disapprove new placements. Midwives cannot create a new practice group without TPA and Ministry approval with regards to where, catchment area and caseload.

857. Midwifery practice groups take on the risk of a small business, but unlike other small businesses including physician-based practices, there is no ability to increase income with effort (no commensurate reward for effort); the practice cannot grow or expand without MOHLTC approval nor can the practice bill for additional services.

858. The particulars of the above 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.

859. 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.

860. 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.

861. Over the period since 1994, midwifery pay fell way behind its comparator professions as detailed in the AOM expert report of Hugh Mackenzie cited below.

862. 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.

863. 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".[557] At the time, midwives focused on ensuring that the new contractor model of compensation did not result in any reduction of their pay.

864. 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.

865. 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.

---

557 AOM Principles of Funding (Exhibit 62).

866. 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 submission 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.[558]

867. 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.

868. 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.

869. 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.

870. 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 AOM-commissioned Hay analysis in 2007, did the Government agree as part of the 2009 contract to undertake a joint compensation review. The review was undertaken by the Government-retained Courtyard consultants July to September, 2010. The review was to inform the contract negotiations which were to start by September 30, 2010.

871. 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

558 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.[559]

872. As well at the time of this Courtyard process the Ministry 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.

873. 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*.

874. 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.

875. 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 prior to 2000, the MOHLTC refused to consider any increase in compensation. See paras. 184-195 of the Application.

(b) During the period 2000 to the current time, the reason was the Government budget did not provide funds for compensation increases.

(c) Prior to 2003, the MOHLTC would not address compensation until a program evaluation was completed.[560] Also, Ms. Lynch testified that the

559 See Appendix 5, Section XVI

560 Affidavit of Remi Ejiwunmi, (Exhibit 66); Testimony of Remi Ejiwunmi, Transcript, September 28, 2016 at pp. 43-44.

MOHLTC would not discuss this further until a new framework agreement for independent contractor status was established.[561]

(d) 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;

(e) 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.

(f) 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 lead to a review and increase in CHC physician funding.

(g) For period from 2008 onwards, MOHLTC deferred addressing the issue as well until it saw the results of the jointly commissioned Courtyard report.

(h) 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.

(i) 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.

(j) 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.

(k) 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.

(l) The AOM pursued MOHLTC's designated "internal' avenues for securing pay equity compliant compensation. The AOM bargained in good faith

561 Testimony of Bridget Lynch, Transcript, September 22, 2016; Testimony of Bridget Lynch, Transcript, September 23, 2016

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.

876. 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.

877. 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.

878. 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.

879. 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.

880. 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.

881. 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.

882. 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 27: COMPENSATION OF MIDWIVES AND CHC PHYSICIANS

A. COMPENSATION OF MIDWIVES

883. In 2013 compensation for a non-rural/remote midwife in Ontario delivering 40 courses of care ranged from $79,360 for a Level 1 midwife to $102,560 for a level 6 midwife.[562] These compensation ranges represent payments received by midwives for the experience fee, on-call fee, secondary care fee, and in the case of level 6 midwives, the retention incentive, based on 40 courses of care. An average course of care requires 55.8 hours of work.[563]

884. In addition to these amounts, midwives also receive an amount equal to 20% of salary towards extended health benefits and an RSP program.[564]

885. Midwives practicing in a rural or remote locations receive up to an additional $7,000 per year in the form of a $125-175 Rural and Remote Supplement on the experience fee for each course of care. Specifically, a midwife in her first year of rural/remote practice receives an addition $125 premium on the experience fee, $150 in her second year, and $175 in all subsequent years. Funds for professional development are provided by the MOHLTC to the AOM in the amount of $1,500 per midwife, however Ms. Stadelbauer testified that this funding "has never been referred to or considered part of midwives' "compensation" by either party."[565] Midwives do not receive paid vacation or paid leave for professional development.

562" Issue Brief by H. MacDermid re: Status of Midwifery Compensation after AOM filed with the HRTO" Affidavit of Melissa Farrell (Exhibit 180, Tab 59).

563 At the time of regulation, the workload analysis relied upon by the AOM and the MOHLTC in their negotiations was the analysis set out in Van Wagner's pre-regulation 1991 thesis, With Women: Community Midwifery in Ontario (Exhibit 22, Tab 3). Van Wagner's analysis arrived at a figure of 48.25 hours per course of care. The AOM's 2007 Workload Analysis updated those figures and increased the hours to 55.48 hours. See: "Chart: Ontario Midwifery Workload, 1993 Historical Benchmark and 2007 Workload Analysis", Affidavit of Kelly Stadelbauer, (Exhibit 112, Tab 15); Affidavit of Kelly Stadelbauer (Exhibit 112) at paras. 34-46.

564 "Issue Brief by H. MacDermid re: Status of Midwifery Compensation after AOM filed with the HRTO", Affidavit of Melissa Farrell, (Exhibit 180, Tab 59).

565 Affidavit of Kelly Stadelbauer (Exhibit 112) at paras. 225-227.

886. The MOHLTC asserts total compensation for a Level 6 midwife, in a non-rural or remote practice, is $192,265.[566] This is, however, an inaccurate and misleading calculation of a midwife's compensation in that it includes a number of non-compensation expenditures which are in fact reimbursements for the costs associated with the practice of midwifery (i.e. liability insurance, operational fee, travel grants and equipment grants).

887. The MOHLTC further asserts that in addition to the $192,265 paid to individual midwives it pays other "valuable additional supplements and one-time grants to eligible MPGs (e.g., rural/remote supplements, second attendant funding, IT software funding, home birth kits, etc.)."[567] These funds represent overhead and reimbursements for work related expenditures and are not compensation to the midwife in the same way that funding received by a CHC for overhead and operating costs is not compensation to the CHC physician.[568] For a full response to the specific items the MOHLTC asserts are compensation, see Appendix 12, Detailed Review of Midwifery Compensation and Funding – Facts vs. MOHLTC Misstatements.

Non-Rural/Remote Midwives Compensation (Based on 40 courses of care)		
	Min (Level 1 Midwife)	**Max (Level 6 Midwife)**
Total (Experience Fee + On-call Fee + Secondary Care Fee + Retention Incentive) X 40 Courses of Care	$79,360	$102,560
Experience fee	$1,450	$2,017
On-call fee	$320	$320
Secondary care fee	$214	$214
Retention Incentive	$0	$13
Benefits (20%)	$15,872	$20,512

Rural/Remote Midwives Compensation (Based on 40 courses of care)		
	Min (Level 1 Midwife)	**Max (Level 6 Midwife)**

[566] Appendix to Form 2 Response of the MOHLTC to the AOM's Application, at p. 3.

[567] Appendix to Form 2 Response of the MOHLTC to the AOM's Application, at p. 3.

[568] See, Appendix to Form 3 AOM Reply To MOHLTC Response And AOM Form 11, at paras. 19-58.

Total (Experience Fee + On-call Fee + Secondary Care Fee + Retention Incentive) X 40 Courses of Care	$84,360	$109,560
Experience fee	$1,450 + $125	$2,017 + $175
On-call fee	$320	$320
Secondary care fee	$214	$214
Retention Incentive	$0	$13
Benefits	$16,827	$21,912

B. CHC PHYSICIAN COMPENSATION

888. CHC physicians are paid on one of two salary grids, the non-under serviced grid or the under-serviced grid, depending on the CHCs location and client population. The base salary for a CHC physician on the non-underserviced grid in January 2013 ranged from a minimum $183,426 to a maximum of $212,438 based on a 35-40/hr work week[569]. CHC physicians also receive benefits equivalent to 20% of their base salary.[570] In addition to these amounts, CHC physicians receive a number of additional benefits and forms of remuneration, including on-call fee of $5,353,[571] 4 weeks paid vacation,[572] 2 weeks of paid

[569] "Spreadsheet of CHC Salary Scales - April 1, 2004 to April 1, 2013" Government Documents – Susan Davey, Vol. 2 (Exhibit 143, Tab 51); "Appendix - Salary-level Deliverables in the CHC and Proposed FHT Blended Salary Compensation Frameworks" Government Documents – Susan Davey, Vol. 3, (Exhibit 145, Tab 103) at p. 1.

[570] "Email from Jill Barber, MOHLTC to Irene Medcof, MOHLTC re CHC funding template for 2007 or 2008" Government Documents – David Thornley (Exhibit 179, Tab 22).

[571] " A Strategic Review of the Community Health Centre Program, dated May 2001" Affidavit of Susan Davey (Exhibit 135, Tab 230) at p. 49; Testimony of MaryRose MacDonald, Transcript, November 9, 2016, at pp. 196-197.

[572] "Appendix - Salary-level Deliverables in the CHC and Proposed FHT Blended Salary Compensation Frameworks" Government Documents – Susan Davey, Vol. 3 (Exhibit 145, Tab 103); "A Strategic Review of the Community Health Centre Program, dated May 2001" Affidavit of Susan Davey (Exhibit 135, Tab 230) at p. 49.

professional development,[573] CME allowance of $2,400/year,[574] and a Free Tuition Program.[575]

889. The base salary for a CHC physician practicing on the underserviced grid ranges from a minimum of $229,111 up to $258,123[576] In addition to the same benefits received by physicians on the non-underserviced grid, physicians on the underserviced grid, are also eligible for a retention incentive of $7,000 under the Northern Physician Retention Initiative or $80,000-$117,600 in the form of a Northern and Rural Recruitment and Retention incentive paid over four years.[577]

1. CHC PHYSICIAN LIABILITY INSURANCE

890. While the midwives position is that liability insurance is a workplace requirement akin to overhead, and not a form of compensation, it also the case that CHC physicians have their insurance paid by their employer.

891. CHC physicians and other physicians in Ontario also have their liability insurance reimbursed by the MOHLTC.[578] Until 2014, the Medical Liability Protection ("MLP") Reimbursement Program covered the cost of physician's insurance premiums over and above the 1986 base fees, and since then, the contribution of physicians to their premiums have increased slightly, indexed to inflation[579]. Family physicians that work in CHCs have the balance of their payments paid for by the CHC, and this cost is categorized as an "operating expense."[580] The government therefore pays 100% of the insurance of CHC physicians, either directly through reimbursements or through funding to the CHCs. CHCs and the OMP are both community-based, managed public services.

CHC Non Under-Serviced Grid Compensation (Based on 35-40/hr work week)

---

573 "A Strategic Review of the Community Health Centre Program, dated May 2001" Affidavit of Susan Davey (Exhibit 135, Tab 230) at p. 49.

574 "Guide to Physician Compensation" Government Documents – Experts (Exhibit 279, Tab 76) at p. 17; Testimony of David Price, Transcript, April 4, 2017 at p. 130.

575 "Discussion Document for Base Review Analysis of Primary Care Programs" Government Documents – Laura Pinkney (Exhibit 160, Tab 110).

576 "Spreadsheet of CHC Salary Scales - April 1, 2004 to April 1, 2013" Government Documents – Susan Davey, Vol. 2 (Exhibit 143, Tab 51).

577 "Compensation, Incentives and Benefits: Healthforce Ontario" Government Documents – Lisa Graves (Exhibit 273, Tab 19) at p. 9.

578 See "OHIP for HC Professionals: Medical Liability Protection (MLP) Reimbursement Program" Affidavit of Kelly Stadelbauer (Exhibit 112, Tab 129).

579 Testimony of Bob Bass, Transcript, March 29, 2017, at p. 263

580 Handbook by Association of Ontario Health Centres on developing a CHC - Phase II: Needs Assessment and Proposal Development" Government Documents - David Thornley (Exhibit 179 - Tab 3) (attached) includes CMPA in operational fees at p. 24

	Min	**Max**
Base Salary	$183,426	$212,438
Benefits (20%)	$36,685	$42,488
On-Call Fee	$5,353	$5,353
Paid Vacation	4 Weeks	4 Weeks
Paid Educational Leave	2 Weeks	2 Weeks
CME Allowance	$2,400	$2,400

CHC Under-Serviced Grid Compensation (Based on 35-40/hr work week)		
	Min	**Max**
Base Salary	$221,350	$258,123
Benefits (20%)	$44,270	$51,625
On-Call Fee	$5,353	$5,353
Paid Vacation	4 Weeks	4 Weeks
Paid Educational Leave	2 Weeks	2 Weeks
CME Allowance	$2,400	$2,400
Northern and Rural Recruitment and Retention (NRRR)	$80,000 - $117,600 (paid over four years) [Cannot be used in addition to Free Tuition Program or at same time as NPRI]	$80,000 - $117,600 (paid over four years) [Cannot be used in addition to Free Tuition Program or at same time as NPRI]
Northern Physician Retention Initiative (NPRI)	$7,000	$7,000
Free Tuition Program	$40,000 (or $10,000 per year)	$40,000 (or $10,000 per year)

PART 28: MOHLTC MIDWIFERY COMPENSATION SETTING

A. Midwifery Compensation Embedded in Contracts and Policies

892. The Ministry, through contractual directives and policies, including the Transfer Payment Agency ("TPA") template agreement, sets the compensation of Ontario's registered midwives.[581] Results of 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. These contracts included:

581 See, for example, " LMCO template letter to Midwife attaching blank copy of the LMCO and MPG Template Funding Agreement AOM (1994-04-21)", Affidavit of Carol Cameron (Exhibit 44, Tab 9); "MPG - TPA Template Funding Agreement (June 1, 1999)", Affidavit of Bridget Lynch, (Exhibit 61, Tab 81); TPA-MPG Template, 2009, (Exhibit 84).

(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.

(e) The 2011 and Subsequent Fee Schedule extensions did not provide for any increase in compensation.

893. Despite provision in the 1993 Program Framework for cost of living adjustments the Ministry 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 which were only applicable if considered employees, and then froze the compensation of midwives from 1994 to 2005.

PART 29: MOHLTC CHC PHYSICIAN COMPENSATION SETTING

1. Community Health Centres

894. 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.

895. 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.

896. AOM Witness Theresa Agnew, a nurse practitioner and head of the Nurse Practitioners Association of Ontario and previously a long time CHC employee, testified concerning this extensive model of collaboration. Many of the care tasks which CHC physician witnesses referred to in their affidavits are, in fact, also provided by other professionals, including nurse practitioners.

897. 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.

898. 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.

899. 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.[582] 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.[583] Most of these locations are situated in the same local areas as midwifery catchment areas and many of the underserviced areas for CHCs which merit the higher physician compensation grid are also underserviced areas where midwives practice. Between 2007 and 2011 CHC funding was devolved to the Local Health Integration Networks (LHINs).

---

582 See Dr. Chandrakant P. Shah and Dr. Brent w. Moloughney, "A Strategic Review of the Community Health Centre Program", Affidavit of Jane Kilthei (Exhibit 1, Tab 17) for a detailed review of this Program and the work of CHC physicians and nurse practitioners.

583 "Community Health Centres in Ontario- Accreditation Canada" Government Documents – Thornley (Exhibit 179, Tab 57).

2. CHC Physician Compensation

900. 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 Nurse II."[584] These salary ranges were detailed in the Ministry's 1991 CHC Compensation Review. These salary ranges are set out in the Morton report.

901. 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.

902. 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.[585]

903. The data originally available to the AOM on which Mackenzie made initial calculations regarding CHC physician compensation has only accounted for Base Salary, benefits and on-call fees.

904. However, through disclosure, it became apparent that from 2004 to 2010 CHC physicians were also eligible for further incentive payments such as 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. [586] During this period in the CHC model, the CCM fee per

---

584 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/)

585 "Community Health Centres in Ontario- Accreditation Canada" Government Documents – Thornley (Exhibit 179, Tab 57).

586 "Options for Aligning CHC Compensation - 17 Aug 2009 - Working Paper" Government Documents – Pinkney (Exhibit 160, Tab 112) at p. 2.

physician depended on the average number of enrolled patients for all physicians (all patients enrolled by CHC physicians were pooled).[587] 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.

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

905. 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.

906. 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).[588] 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:

(a) FFS Flow through Physician Compensation Adjustments
(b) Comprehensive Care Capitation and Primary Care Physician Incentives and Bonuses
(c) Continuing Medical Education payments
(d) Per patient rostering fee[589]

907. 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. These were not regarded as part of the physician's total compensation.

Coping with Uncertain Data: Interim Payments

908. 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:[590]

---

587 "Options for Aligning CHC Compensation - 17 Aug 2009 - Working Paper" Government Documents – Pinkney (Exhibit 160, Tab 112) at p. 2.

588 "Update on CHC Physician Compensation for PHC Executive, dated March 2, 2010" Affidavit of Laura Pinkney (Exhibit 158, Tab 206).

589 "Overview: Harmonization of Community Health Centres, dated May 15, 2009" Affidavit of Susan Davey (Exhibit 135, Tab 238).

590 "CHC Salary Scales Sent from OMP to Courtyard" Affidavit of Katrina Kilroy (Exhibit 91, Tab 55).

year	Not designated underserviced	Northern/designated underserviced
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

909. However, these figures to do not account for the additional incentive payments introduced as a result of OMA bargaining.

910. The OMP did not disclose the further incentive payments to Courtyard and AOM unaware of them.

911. 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."[591] In May 2007 the Primary and Community Care Committee (PCCC) approved interim and retroactive incentive payments to be made to CHC physicians" as follows:[592]

- 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) [593]

912. 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."[594]

---

591 "Implementing the Primary Care Incentives in the 2004-08 Agreement between MOHLTC and OMA (est 2005)" Affidavit of Tara Kiran (Exhibit 173, Tab 88).

592 "Internal MOH Briefing Note by David Thornley re: CHC Physician Compensation Payments (email attaching AOM0013473)" Government Documents – Thornley (Affidavit 179, Tab 25) at p. 4.

593 "MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups - Summary (2008-01-01)" (Exhibit 132).

594 "Letter from G. Smitherman to G. Stein (President, South-East Ottawa Community Services) re: Harmonized Compensation for CHC Physicians (Nov 2005)" Affidavit of Theresa Agnew (Exhibit 129, Tab 49).

913. Based on the documentation which has been produced to the Applicant to date, it is difficult to calculate precisely the increase in compensation to CHC physicians during this period. It is clear that payments for physician incentives and bonuses were made in December 2005,[595] June 2006,[596] April 2007 and March 2008.[597] 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. [598] 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 claims[599] 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.[600]

914. 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.

Controversy Caused by Rostering

915. The requirement that CHC's roster patients to the physicians caused a degree of controversy. This was because many patients that physicians billed for had never even seen a physician, and were cared for by a Nurse Practitioner. Also stoking controversy was the fact that rostering promoted billing for services that were considered to already be part of quality primary care. Despite these concerns, the MOHLTC continued the direction to roster CHC patients. An internal MOHLTC memo from 2009 notes that "the physicians are receiving the incentive and bonus payments for the work of NPs".[601]

---

595 "Overview Harmonization of Community Health Centres (2009-05-15)" Affidavit of David Thornley (Exhibit 132, Tab 27).

596 "Overview Harmonization of Community Health Centres (2009-05-15)" Affidavit of David Thornley (Exhibit 132, Tab 27).

597 "MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups - Summary (2008-01-01)" (Exhibit 132).

598 "MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups - Summary (2008-01-01)" (Exhibit 132).

599 "MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups - Summary (2008-01-01)" (Exhibit 132).

600 "Memo from J. Barber (Manager, CHC Program) to D. Hole (Executive Director, South-East Ottawa Community Services) re: Salary Surpluses (Jan 2007)" Affidavit of Sue Davey (Exhibit 142, Tab 108).

601 "Overview Harmonization of Community Health Centres (2009-05-15)" Affidavit of David Thornley (Exhibit 132, Tab 27).

The 2008 Physician Services Agreement

916. 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.

917. 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"[602] As of 2008 the base salary of CHC physicians in CHCs Not designated underserviced was $124, 460 to 149, 945 and in underserviced CHCs was $157, 772 to 190, 074.[603] In 2009 the base salary was 140, 434.55 to $157, 142.02 for not underserviced CHCs and $165, 345.56 to $199, 197.52 for underserviced CHCs. [604]

Collapse of the blended salary model

918. The goal of the MOHLTC was for the incentive payments to be based on actual patient enrolment after April 1, 2009.[605] The goal of the MOHLTC was for incentive payments to be based on actual patient enrolment after April 1, 2009.[606] 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 substantial overpayments to physicians in the previous years.

Introduction of a full salary model

919. In January 2010, the Physician LHIN Tripartate Committee (PLTC) decided that CHC physicians would move to a fully salaried compensation model effective April 1, 2010.[607] The new salary ranges were based on CHC physician FTE base

602 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

603 "Options for Aligning CHC Compensation - 17 Aug 2009 - Working Paper" Government Documents – Pinkney (Exhibit 160, Tab 112) at p. 2

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

605 "Internal MOH Briefing Note by David Thornley re: CHC Physician Compensation Payments (email attaching AOM0013473)" Government Documents – Thornley (Affidavit 179, Tab 25) at p. 4.

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

607 "Update on CHC Physician Compensation for PHC Executive, dated March 2, 2010" Affidavit of Laura Pinkney (Exhibit 158, Tab 206).

salaries and an estimate of the CHC value physician FTE annual incentives and bonuses.[608] In other words, the value of the incentives were rolled into the base salary of CHC physicians.

920. 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.

921. 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)[609]		
Payment Element	Communities not designated underserviced	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
+ 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

608 "Update on CHC Physician Compensation for PHC Executive, dated March 2, 2010" Affidavit of Laura Pinkney (Exhibit 158, Tab 206); "Letter from MOH to Champlain LHIN re physician compensation increase (May 2010)", Government Documents – Laura Pinkney (Exhibit 160, Tab 138).

609 "Update on CHC Physician Compensation for PHC Executive, dated March 2, 2010" Affidavit of Laura Pinkney (Exhibit 158, Tab 206).

Conclusion

922. The AOM submits that the evidence set out in the Part A submission provides the foundational support to conclude that the MOHLTC as alleged in paragraph 62 of Schedule A to its November, 2013 application, as stated below:

(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,"39 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.

923. Accordingly, the AOM submits that it has overwhelmingly proven that midwives have suffered adverse gender impacts.

PART 30: MOHLTC FAILURE TO DEVELOP AND APPLY GENDER EQUALITY PROMOTING AND DISCRIMINATION PREVENTION SYSTEMS TO DETERMINE MIDWIFERY COMPENSATION, FUNDING AND SERVICES

A. Introduction

924. Since 1993, the initial rough pay equity exercise of the MOHLTC working in a Joint Work Group cooperative negotiation process, the MOHLTC has failed to develop and apply gender equality promoting and discrimination prevention systems to determine midwifery compensation, funding and services.

925. The Joint Work Group process reflected in the Morton report was a process that provided a equality promoting and discrimination prevention system for creating the initial compensation to be paid to midwives to provide midwifery services for the OMP. This process used a collaborative negotiations process between the MOHLTC and the AOM based on an evidence-based rough job evaluation process using the factors from the *Pay Equity Act* of skill, effort, responsibility and working conditions and using two key comparators, the CHC family physician and the CHC senior nurse/nurse practitioner to establish the new equitable and relative positioning of the midwife in the funded health care system.

926. Since 1993, the evidence clearly establishes that the MOHLTC did not ever again engage in such a gender equity process with the AOM again. As well, the evidence establishes that the MOHLTC did not have in place, nor did it develop, implement or apply any type of gender inclusive system(s), framework, policies,

or processes to address human rights impacts for midwives as a vulnerable female profession subject to ongoing stereotypes and prejudices.

927. In fact, as detailed below the MOHLTC agrees that it did not have such systems in place nor did it carry out such processes as it maintains it did not carry out any pay equity/human rights analysis during the Joint Working Group process and did not need to carry out one after that.

B. Necessity for Gender Inclusive Systems, Policies and Practices to Prevent and Eliminate Gender Bias and Realize Gender Equality

928. Yet the MOHLTC expert Dr. John Kervin testified that a lack of equality promoting systems, policies, processes and practices allows gender bias to enter into the setting of compensation.

> *Discrimination is really difficult to get rid of. You don't change people's heads readily….But what you can do is change what the rules and procedures are in terms of things like compensation…So you work on compensation, you get good job evaluation, you get much fairer compensation methods, and take care of adjustments, do regular pay equity assessments, and then you can begin to worry about, "Okay. How do I get rid of the bias in the first place?", because this is an age-old problem and whatnot…What makes things better is a really good, sound job evaluation system that affects the compensation for midwives, and then and only then, after that's taken care of, can you worry about how do we change attitudes and behaviours… That's why I want to see a better, more effective job evaluation system that you could apply directly to compensation for midwives. Find out how much of a problem there is, if there is one at all, and then you've got hard data, and you go ahead and you make the changes".*[610]

929. As Dr. Armstrong and Mr. Durber testified that compensation-setting and funding for midwives requires a gender inclusive and sensitive, evidence-based systematic approach through policies, systems and processes that examine the work and ensures the compensation is free of gender bias and discrimination.

930. The International Labour Organization also identifies the need for such an approach in order to establish compliance with ILO Convention 100, the Equal Remuneration for Work of Equal Value Convention:

> *It requires adopting a new way of looking at job characteristics, modifying the perception of women's work compared to men's work, re-examining the pay systems in force in organizations and, ultimately, raising the pay for female-dominated jobs.*[611]

---

610 Testimony of John Kervin, Transcript, March 27, 2017, at pp. 163 - 166.

611 ILO (2009) Promoting Equity: Gender-Neutral Job Evaluation for Equal Pay: A Step-by-Step Guide, 2009 MOHLTC Expert Witness Documents, Volume I (Exhibit 279, Tab 19), at p. 2.

931. The ILO highlights that such an approach while taking time and resources, ensures the realization of the right to be free from sex discrimination in pay and the benefits of that right.

The main benefit of implementing pay equity is the actual sanctioning of female workers' right to equality, whereby their skills are recognized and their job tasks are accorded value, not only symbolically, but in very concrete terms, through pay adjustments. It is therefore a question of dignity and recognition on the part of their superiors and co-workers, the positive impacts of which have been emphasized by many female workers. Pay adjustments can also have a significant impact on these workers' capacity to provide a decent standard of living for their families and increase their financial security in retirement.[612]

932. There is great irony in there proceedings: the MOHLTC expert witnesses provided extensive analysis and the MOHLTC counsel meticulously questioned Mr. Durber with respect to Mr. Durber's job evaluation process in his assessment of midwifery compensation, best practices in job evaluation processes and where they alleged, we submit, erroneously that Mr. Durber was deficient in his process and analysis. And yet, none of the processes undertaken by Mr. Durber or the best practices cited by the experts and MOHLTC counsel were undertaken by the MOHLTC to determine the equitable and appropriate compensation of midwives. The MOHLTC set midwifery compensation and funding without much thought at all other than to opportunistically save money.

C. The Joint Work Group Process and Morton Report Provided Equity Process and Measuring Stick

933. The AOM concedes that the 1993 Joint Work Group process and resulting Morton Report was not a comprehensive job evaluation of the work of midwives. That is why the AOM application described it as a "rough" pay equity analysis and Jane Kilthei described it as a "pay equity exercise".

934. However, it provided the necessary initial human rights analysis of the work and pay of midwives and their primary care community based comparators in order to get the compensation system in place for start of regulation as of January 1, 1994. It is precisely because it was "rough" and based on entry level competencies and a situation where the midwives had not yet started to work as regulated midwives, that the AOM and Mr. Durber call for monitoring and a further review of the work and pay of the midwives and their comparators by 1996.

935. The Joint Work Group process and the Morton Report arrived at a gender equality "measuring stick" that gave a reasonably objective measure of the value of midwifery at the time. As a compromise, the parties agreed to a comparison to

---

612 ILO (2009) Promoting Equity: Gender-Neutral Job Evaluation for Equal Pay: A Step-by-Step Guide, 2009 MOHLTC Expert Witness Documents, Volume I (Exhibit 279, Tab 19), at p. 4.

the lowest earning CHC physician on the non-underserviced grid for all midwives, urban and rural. As a result, the highest earning midwife (at $77,000) would earn 90% of or $3,000 less that the lowest earning CHC physician (at $80,000 without on call fee) and $21,000 more than the top earning senior nurse/nurse practitioner ($56,000).

936. Further, as an initial compensation revision procedure, the parties agreed that the MOHLTC would adjust the compensation in light of COLA requirements.

937. However, one error in the Morton process, as Ms. Davey rightly pointed out in her testimony was that the comparison should be between top of the scale of each comparator: *"it might be more accurate to compare top of scale to top of scale, and bottom of scale to bottom of scale perhaps..."*[613] This reasoning is also found in Mr. Durber's report who adjusted the compensation comparisons to use the top of the salary scale of the CHC physician.

D. Courtyard and Hay Affirmed the 1993 Comparator Analysis

938. Two additional independent compensation reviews have been carried out since the Joint Work Group process. The 2003 and 2004 Hay Compensation reports commissioned by the AOM, and the Courtyard Report commissioned by the MOHLTC.[614] Hay Group principal Moshe Greengarten testified that his team:

> *reviewed the Morton report as part of our preparation and research for the project, and came to the conclusion that the Morton report was reasonable and produced a credible recommendation or results, I should say, in terms of setting out key principles for compensating Ontario midwives, and in particular, set out what we believed, based on our reading of the Morton report, set out a reasonable, internal, or let's say equity structure for the midwives as compared to other health care professionals.*[615]

939. Without any equity systems in place in the Ministry for midwifery compensation, the rough equity lens used in 1993 was never used again or refined. As well, there was no system for ensuring an institutional memory of the process.

940. For example, Ms. Pinkney who had responsibilities for the midwifery file from 2006-2012, testified that she had not been briefed on how the Morton report had been negotiated.

---

613 Testimony of Sue Davey, Transcript, October 21, 2016, at p. 52.

614 "Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report" Affidavit of Moshe Greengarten (Exhibit 124 , Tab 4); "Association of Ontario Midwives – Compensation Review (June 2004) - Hay Group Report" Affidavit of Moshe Greengarten (Exhibit 124 , Tab 5).

615 Testimony of Moshe Greengarten, Transcript, October 13, 2016, at p. 14.

Q. So when you were analyzing the Courtyard report, you didn't understand how it had originally been set in 1993 with the Morton report?

A. I certainly understood the Morton report had been used in terms of determining an initial salary, but in terms of the actual -- how that was negotiated, I was not familiar with those specifics, no. [616]

941. The Hay Group report affirmed the principles of the Morton reports, but the MOHLTC dismissed the findings, disagreeing with its methodology but without any assessment of the work of midwives:

Q. So they make a professional assessment by looking at the work, but you haven't yet looked at the work, but you're disagreeing with it. Is that fair to say?

A. Sure.[617]

942. The Courtyard review was undertaken jointly in the summer of 2010 by the MOHLTC and the AOM; the Joint Steering Committee and Courtyard concluded that the CHC physician and NP remained the most relevant and appropriate comparators to use in the compensation review:

The 1994 Morton report found that the income of a midwife should be somewhere above that of a primary care nurse and below that of a Community Health Centre family doctor, taking into account a variety of factors, including training, scope of practice, responsibility, overtime and other requirements. These comparators evolved slightly in 2004 based on the findings of the Hay Report, which replaced primary care nurses with nurse practitioners (a nursing category that was not in existence formally in 1993). We see no reason to change this positioning, and believe it has only been reinforced given the history and development of both the profession and maternal care in the province over the past 16 years.[618]

943. However, the MOHLTC's out of hand dismissal of the principles articulated in the Courtyard report ensured that there was no longer an objective measuring stick in use by the MOHLTC.

E. MOHLTC Admits It Had No Policies or Processes after Morton to assess midwifery compensation

944. The MOHTLC witnesses have been quite forthcoming about the lack of policies, processes, structures, mechanisms, and frameworks in which to make assessments about midwifery compensation.

---

616 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p.109.

617 Testimony of Sue Davey, Transcript, November 1, 2016, at p. 92.

618 Report by Courtyard Group for MOH re Compensation Review of Midwifery (September, 2010), AOM0000567, FN 47 to Affidavit of Kelly Stadelbauer, (Exhibit 112) at p. 41.

945. Key examples of the testimony of the MOHTLC witnesses about the absence of equity systems, policies and practices are set out below:

(a) Nancy Naylor testimony

Q. " in terms of understanding the Ministry's policy, is that it doesn't have a process for evaluating whether or not the value of the nurse practitioners' work should be compensated appropriately relative to the value of other providers" …

A. Right.

Q. So, just to understand, you don't have any system for sorting it out other than maybe if there were to be a shortage of them, you might have to pay them more?

A. Well, that would be an important signal."[619]

946. Ms. Naylor testified that there is no formal system regarding provider compensation, but the MOHLTC pays attention to "market forces":

Q. So, I guess there isn't a particular policy that says that we should provide equitable compensation across all the providers that we are responsible for compensating?

A. I think that's a broader definition of equity than we would apply systematically when we are making funding model decisions, you know, or compensation decisions. So, you know, typically definitions of health equity are from a patient's perspective.

Q. So, I think you're saying the answer is no, there isn't any overall system focus?

A. There is not a formal sort of scaling system or quantitative system that we would adhere to say, you know, we expect or we have a view about the relative proportions of provider compensation, but we do pay attention to market forces. We do pay attention to, you know, patient preferences because we actively solicit patient preferences, and the government does from time to time intervene to create options for patients with respect to access to providers that, you know, would not happen as a result of market forces alone and, for example, the PSW investment is one of them. Some of the recent investments in interprofessional compensation, even the creation of new forms of providers like midwives or a recognition of new forms of providers like midwives or nurse practitioners or physician assistants would be examples of that.[620]

---

619 Testimony of Nancy Naylor, Transcript, November 3, 2016, at p. 94.

620 Testimony of Nancy Naylor, Transcript, November 3, 2016, at p. 79.

947. The Ministry's reliance on market forces in the absence of policies and processes ensures that the gender biases in the marketplace enter into health care provider compensation.

948. Dr. Chaykowski has written on this: *"So the labour market experience of women continues to differ significantly from that of men, but not always in ways that are beneficial to women. This supports the argument for the further development of labour market policies."*[621] The relationship between market forces and systemic gender discrimination is detailed in Dr. Armstrong's report.

(a) Ms. Pinkney's testimony:

Q. for the purposes of those 2008 negotiations, did you ever attempt to position the midwifery compensation between the actual value of the CHC physician salary including base and incentives and the nurse practitioner?

A. In 2008, to my understanding, no.[622]

(b) Ms. Davey's testimony:

Q. And did the Ministry have a certain position at that time about what the percentage compensation increase should be?

A. The Ministry had previously made a recommendation on a salary scale for our compensation scale for midwives up to 90,000, and so that would have been in our minds as a workable amount of compensation, something to work toward.

Q. And I guess that's one issue. My other issue is whether or not there was a general labour relations compensation policy at that point as to what -- whether there should only be a certain percentage increase in compensation?

A. Well, certainly at this time, it was I believe 2 percent that the government wanted everyone to be maintained as part of the labour strategy… And certainly, the direction to us was to find ways to increase compensation that were not strictly salary.

Q. Right. So in other words, amounts were characterized as incentives that might otherwise have been described as compensation in order not to come under or in order not to exceed the 2 percent.

A. In order to achieve -- we felt, of course, that 2 percent was not enough...for an increase, and so we needed to look for other ways to achieve an increase that wouldn't fly in the face too daringly of a 2 percent increase that was what was going forward for many other people in the sector or professions or organizations

---

621 Testimony of Richard Chaykowski, Transcript, March 31, 2017, at p. 5.

622 Testimony of Laura Pinkney, Transcript, November 8, 2016, at p. 52.

in the sector at the time. So we were -- so that was what we would be bringing as a principle, basically, to the AOM to say, "Here's the thing: We want -- we know that midwives need to have an increase and together, we need to find the best way to structure that increase, so that it has the most chance of being approved by fitting into the priorities that the government has."

Q. And so let me understand then: When you got approval for the 5.3 million for compensation, do I take it you're saying now though that there was a restriction on how that amount could be paid out? It had to be characterized a certain way?

A. I don't know if it was a restriction, but it was certainly characterized as your request for your funding increase, your compensation increase will be most favourably received if you develop a structure for that increase that isn't solely related to salary.[623]

949. Ms. Davey testified to the lack of process available to midwives to know of their comparators' worth and the lack of an objective process to determine the appropriate increase; both of these factors placed midwives into a disadvantage in their compensation:

A. I did not tell the AOM personally what the physician rate was increased to in the CHC.

Q. Why would you not do that if you're trying to keep them in alignment and monitor their comparators?

A. We weren't having discussions at that time in the Ministry of increasing midwives' compensation, so there was no -- and when they, when the AOM submitted their Hay report, we didn't ask for the Hay report. It was submitted to us as some information. We had some questions. We asked the questions. That was the end of that.

Q. Because -- okay. So then we should assume there isn't any ongoing monitoring of their compensation because you weren't really that interested in the report.

A. This wasn't our report. We read the report, we had some questions, and we posed the questions.

Q. And otherwise, ignored the report?

A. The report did not form the basis of our review of compensation and our subsequent increase in compensation to our midwives, that's correct.

Q. You didn't take it into account at all?

---

623 Testimony of Sue Davey, Transcript, November 1, 2016, at pp. 162 – 164.

A. We didn't commission the report. We didn't -- we did not participate in setting the terms of reference. It was not our report.

Q. Did you commission the '99 report for the CHCs?

A. Well, as I said to you last time, I think I said, I believe the Association commissioned that on its own, but I'm not 100 percent sure.

Q. Well, even if it did commission it on its own, you certainly paid attention to it.

A. We had another Hay report subsequent to that in which we were partners with the Association, yes.

Q. Right, but the first one is referred to in a number of government documents, the '99 one…if somebody commissions a report about their compensation, are you saying it's just here that -- the Hay report, you didn't take it into account? I find it kind of stunning you would not take a report that you were given by the Association into account with respect to analyzing their compensation.

A. Well, certainly, we read the report and we provided them with our feedback on the report, and in the end, when we were preparing our compensation increases, we were working with the Association to develop the salary scales and the new compensation increases that would be implemented. So we worked with them and together we came up with what the compensation would be.

Q. Well, no. The 5.3 million that you came up, they didn't have anything to do with that. You just told them that was the amount of money.

A. Yes, that's right.[624]

950. Ms. Davey also testified to the compensation restraint policies that were applied to midwives:

Q. …you were responsible for implementing the September '93 framework which required you to consider whether there were COLA adjustments, but you didn't have any process for monitoring it and you're saying the Ministry didn't provide, as a matter of policy, COLA adjustments during that time?

A. Certainly during this period of time, during the time when the Conservative government was in power, there were no COLA adjustments that would be allowed to be offered. So, it was not included in any of our budgeting.

Q. So, can we find a document that says that Conservatives didn't allow COLA? Am I going to find that anywhere?

---

[624] Testimony of Sue Davey, Transcript, November 1, 2016, at pp. 96 – 98.

A. I don't know if you would. I don't think we have any of those documents, but that is -- it was definitely a time of constraint, and we were definitely not welcomed to invite any increases that were due to COLA in our budgeting processes.

Q. …Was it your understanding you didn't have any flexibility in the Ministry and in this program to provide any increased compensation to midwives?

A. Yes. I think that's fair to say.[625]

F. No Consistent Policy for Cross Canada Midwifery Jurisdictional Comparisons

951. There was no policy where midwives would be compared to the rest of Canada but rather this was done as a request from the Minister: Ms. Pinkney testified: "Minister thinks reference point should be other jurisdictions, not necessarily other professions."[626]

952. The evidence shows that there was no appropriate rationale for this decision other than to try to avoid the CHC physician comparison found in the Courtyard report that resulted in a 20% equity adjustment recommendation. There was also no investigation as to whether midwifery work and pay in other provinces was free of sex discrimination and there was no benchmark, strategy or procedure set for the Ontario midwives to measure themselves against their provincial counterparts, as Ms. Pinkney testified to:

"A. I don't recall there being a specific peg that we had set for midwifery. […]

Q. What did you think you needed to be? If jurisdiction was your comparator, where did you think you needed to be?

A. Comparable, and --

Q. Meaning equal?

A. Within comparison. So I wouldn't necessarily say it had to be equal. It's just we were looking at where we fit within other jurisdictions."[627]

G. Lack of Policies, Processes or Systems to Evaluate Work and Pay of Midwives and Comparators on Equitable Basis

---

625 Testimony of Sue Davey, Transcript, October 21, 2016, at pp. 21 - 23.

626 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 83.

627 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 87.

953. This pattern of no policies, processes or systems to evaluate the work and pay of midwives has persisted since 1993. Ms. Stadelbauer testified to the continuation of MOHLTC behaviour discussing meeting with ADM Susan Fitzpatrick:

Q. …She heard our frustration, heard our need for a process, and clearly absorbed the chart with the gap that we had given the Minister. She seemed to have no answer, of course, for how compensation is determined, if not through an evaluation of skills, education, responsibility and working conditions, but clearly got this point." […]

Q. So, you wanted a compensation evaluation to evaluate skill, education, responsibility and working conditions of midwives; is that fair?

A. Yes. That's fair.

Q. And that would be done relative to other comparators?

A. Well, compensation is always relative to other comparators.

Q. Right. That's how a compensation evaluation is done?

A. Yes.

Q. And you put that method of evaluation forward to the Assistant Deputy Minister as the way to do a compensation review?

A. Yeah. And I think our point to her was, if not this compensation valuation review, how else would you determine compensation? What other process would you use and she didn't have the answer for that." [628]

954. The only compensation policy that seems to be consistently applied by the MOHLTC to midwives since 1993 are budgetary policies of fiscal and compensation restraint and a focus on increasing the number of midwives and extending midwifery services instead of increasing midwifery compensation.

955. The application of budgetary fiscal and compensation restraint policies in light of the need for ongoing human rights/pay equity adjustments to midwifery pay to keep it free of sex discrimination was highly problematic, and has been highlighted in Appendix 5 Overview Summary of Evidence by Chronological Eras since 1994.

956. However, the testimony of Katrina Kilroy provides a good summary of the discriminatory application of this legislation and policy:

they were sort of picking and choosing when these Acts that were specific to employees would apply to us as independent contractors, and we didn't think that

628 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, at pp. 120 -121.

was fair. We thought there was a mechanism either they both -- the spirit of both should apply or the spirit of neither should apply, and either one of them would allow them to -- either one of those approaches would allow them to respond to the Courtyard report."[629]

The MOHLTC, who would not extend bargaining rights to midwives, rationalized the application of this legislation and policy to midwives as follows:

"Q. … and this [document] is referring to the fact that the policy statement applies, although not the Act, and the reason the policy statement applies, just so that I understand this, is because the midwives bargained with the Ministry, and because they bargained, the policy statement applies?

A. That is what the briefing note says at the bullet that says: "The Association of Ontario Midwives bargains on behalf of the registered midwives in the province and, as such, the policy applies to midwives." That's what it says here.

Q. So, it's the fact that they negotiate with the Ministry that makes it apply".[630]

H. No job evaluation, compensation review, or analysis of the midwifery work after Morton

957. The MOHLTC witnesses testified that there has been no job evaluation or compensation review after the Morton Report that they have relied upon to determine midwives' compensation.

(a) Ms. Davey testified as follows:

Q. … I just want to go back to your statement … there was never any further examination of the skill, effort, responsibility and working conditions of those professions after this process. Would you agree with me that, without that, it would be difficult to monitor whether the relative positioning of those professions was still fair and appropriate?

A. I think that the skill, effort and responsibility changed slightly for many of the health professions in that time frame. I don't think there was significant change, a significant enough change to warrant another job evaluation. And anyway, the purpose of this job evaluation was really to set the initial -- the initial compensation level, and from then on, we would determine how we would grant increases in compensation. It wouldn't be necessarily by going back through another job evaluation process.

---

629 Testimony of Katrina Kilroy, Transcript, October 6, 2016, at p. 178.

630 Testimony of Laura Pinkney, Transcript, November 8, 2016, at pp.154 – 155.

Q.…So, your first response was to say you didn't think there was really much of a change in the skill, effort, responsibility and working conditions of those professions after that?

A. What I was saying was I'm sure there have been and were some changes in the responsibility level of all of the professions that, well, certainly the primary care professions that we looked at.

Q. All right. So, you think there was a change to them but you didn't think it was necessary to do a job evaluation to determine the relative change; is that fair to say?

A. In the end, the way that we addressed the compensation issue was not through job evaluation.[631]

958. Ms. Davey testified that in her view the initial Joint Work Group process did not include any kind of analysis to ensure that the new compensation and funding of midwives on regulation was free of sex bias:

We didn't ever look at gender or discuss that in terms of our comparators or midwifery, no…. the task we were undertaking didn't require us to look at gender bias, and this was not something the AOM brought to the table that they wanted to do, so there was -- we were just, we were all just proceeding with our job evaluation and our setting of our compensation, but it really wasn't to be about -- we never discussed pay equity and so we didn't ever look at it from that kind of angle.[632]

959. Ms. Davey testified that subsequent to the Joint Work Group process, the MOHLTC did not ever again did a job evaluation of the work of midwives[633]:

That's correct…the funding working group, it was a one-time thing. It was point in time. We were doing a job evaluation so that we could set the compensation for a newly-regulated health profession, and we didn't ever come up against anything similar to that again where we felt it was necessary to do another job evaluation. That was -- it was for a purpose, it served its purpose, and then we moved on."[634]

"Q. And you've told us that you haven't done any skill, effort, responsibility or working conditions analysis of the midwife.…

---

631 Testimony of Sue Davey, Transcript, October 21**,** 2016, at p. 30 - 31.

632 Testimony of Sue Davey, Transcript, October 20, 2016, at p. 22 - 23.

633 Testimony of Sue Davey, Transcript, November 1, 2016, at p. 179.

634 Testimony of Sue Davey, Transcript, October 20, 2016, at p. 22.

A. Not since 1993." [635]

I. Failure to Continue Post Regulation a Cooperative Negotiations Process To Address Equity Issues on a Regular Basis

960. The AOM has not been provided a regular and functional negotiations processes since regulation; whereas the OMA has been provided a regular opportunity to negotiate their contract for physicians.

J. Lack of a Gender Inclusive and Sensitive Budgetary and Policy Process

961. The MOHLTC witnesses were forthcoming that there was no process built into the MOHLTC annual budget process where midwifery compensation would be planned for, nor was there a process or even contemplation of a process for any kind of equity adjustment.

962. Ms. Davey testified that:

(a) there wasn't any provision in this budgeting for increased compensation over those periods of time other than the compensation necessary to be paid to the new registrants or midwives or they may have come from the internationally trained program too, whoever the new midwives were*:* "That's correct"[636]

(b) if the MOHLTC had made pay equity funding a separately designated amount of money in the budget, "It would make it much easier to fund pay equity adjustments if you had it in your budget."[637]

963. Dr. Chaykowski testified that the MOHLTC's use of "a gendered-based budgeting approach to the funding would assist in making sure or at least as a mechanism of looking at the pay of midwives*".* He also stated:

if one is trying to develop a richer model, then that may also be a consideration that I think should be on the table. I think that, you know, recent experience, for example, with the federal budget in trying to factor these kinds of issues into the budget process is a good first step and obviously more work can be done there. But I think, as a matter of principle, it's definitely an important thing to consider.[638]

964. However, Ms. Davey testified that this kind of approach was not taken by the MOHTLC:

---

635 Testimony of Sue Davey, Transcript, November 1, 2016, at p. 89.

636 Testimony of Sue Davey, Transcript, October 21, 2016, at p. 68.

637 Testimony of Sue Davey, Transcript, October 20, 2016, at p. 136.

638 Testimony of Richard Chaykowski, Transcript, March 31, 2017, at p. 36 - 37.

Q. … we've seen from the budgeting process documents that we've got before that unless something is in a results-based planning document for the budget for the next year, there's not going to be any compensation increase….Is that fair?

A. That's right, but the paperwork that goes into that final decision starts out very differently than how it ends up, and so lots of things fall off the table and are put on the table during the results- based planning process. So in the end, the document reflects the priorities of the Ministry for that particular business planning process.

Q. So in the fall of 2003, which would be when you were creating the results-based plan, was there any document put forward by your branch about increasing midwifery compensation?

A. Well, as I was trying to say, I don't know when the results-based planning process happened that particular year because of the election, and so if -- so what would have gone forward would have been the new government's, our new government's business plan, and it was not included in that, I don't believe, because this government was not yet ready to ask for an increase for compensation for midwives. […]

Q. … when were you instructed to come up with a proposal for compensation then?

A. In December of 2004.[639]

K. Lack of monitoring processes for midwifery compensation by MOHLTC relative to the compensation of others

965. Ms. Davey acknowledged that comparisons with other professions is important in the MOHLTC assessment of compensation but did not have any understanding of how to do that to ensure female dominated work was free of sex. She testified that there were a number of approaches to compensation assessment more generally:

…ideally, what you would want to do is compare to the same job. If that were possible in the province of Ontario, that would be an ideal situation, like a nurse to a nurse. Can't do that, so you fall back on using other approaches which is to look at how did other health care -- what were the increases to other health care sector professional groups. And so that's very important to informing decisions about what is appropriate compensation, reasonable compensation for a particular group. It says something about where the market is going for similar types of professions.[640]

---

639 Testimony of Sue Davey, Transcript, November 1, 2016, at pp. 101 – 104.

640 Testimony of Moshe Greengarten, Transcript, October 13, 2016, at pp. 250 – 251.

Certainly we are aware that an increase to any comparable or related health profession -- increase to a compensation for one, puts pressure on increases to compensation in others. And so in that regard, yes, you're certainly aware that when you're setting a compensation level, it's not being set in a vacuum, and it has an influence on the need for compensation -- a look at compensation in other providers."[641]

…one of the things that we would say -- would have said within the Ministry is that, as soon as you peg another provider who is providing some of the same services or has an overlap in their scope, that it puts pressure on other providers who are working with that particular profession.[642]

966. In January, 2001, Sue Davey in response to a request for an equitable compensation adjustment which included a cost of living adjustment back to 1994, stated that there was no money in the budget but that the MOHLTC was monitoring comparable professions.

However, the Ontario Midwifery Program and the Ministry of Health and Long-Term Care remain committed to the fair compensation of Ontario midwives and will continue to monitor comparable professions to ensure that the scale remains in line with them."[643]

967. However, the evidence discloses that no such monitoring was in fact taking place and instead a compensation freeze remained in place until 2005.

968. Ms. Davey testified that she undertook monitoring with respect to other comparators to ensure midwifery pay was equitable:

Q. What was your view at this point? You said you were keeping an analysis and you were keeping -- making sure they were in line.

A. I was keeping track of the salary increases across the providers in the CHCs and the nurse practitioners.[644]

969. However, when pressed for details she admitted that this was an informal process and monitoring minimal information. Ms. Davey testified to the monitoring process she had in place:

"Well, it's not a very formal process, and it was not a very difficult task at that point to keep track of any comparable profession that might have had an increase in that time frame because there hadn't been increases in that time

---

641 Testimony of Sue Davey, Transcript, October 21, 2016, at pp. 42 – 46.

642 Testimony of Sue Davey, Transcript, October 21, 2016, at pp. 192 – 196.

643 Testimony of Sue Davey, Transcript, October 21, 2016, at p. 193.

644 Testimony of Sue Davey, Transcript, November 1, 2016, at p. 88 - 89.

frame. So, keeping track of that was not difficult and … then keeping track of or commenting on the fact that the nurse practitioners' scale was 57 to 70 was keeping track of what has been happening out in the environment…

And I'm saying it wasn't a very formal process. It wasn't something that was written down. But certainly I had knowledge of the comparable professions that we had used in our comparators who are the CHC physician and the CHC nurse, and those positions had not been given increases. And by monitoring or making sure that you're aware of any changes in the landscape like the addition of nurse practitioners and what that salary scale was approved at, those are -- that's how I was monitoring, if that's the right word."[645]

"Q. So moving forward, what was your system for monitoring the comparable professions to ensure the midwifery scale remained in line with them?

A. There really wasn't a formal system. It was really just keeping an eye on the landscape, and making sure that we were familiar with what was going on within the health care system. It was not a formal...I can only say that we were quite familiar with the changing compensation within CHCs and within primary care itself, and no further monitoring was really necessary."[646]

"Q. So, did you have any process for monitoring what the cost of living was in relation to the commitment in the Framework Agreement?

A. It was not a common practice in the Ministry to make COLA adjustments in funding programs. So, no, we were not monitoring it.

Q. But didn't you understand what was in the Framework Agreement to be an agreement you had reached?

A. An agreement that from time to time that a COLA increase might be considered, yes, but it hadn't been, and it was not.[647]

970. Mr. David Thornley, a former Community Health Branch employee testified that, he was unaware of what was happening with respect to the compensation of midwives over the time that he was there; that is, his testimony demonstrated that there was no mechanism within the branch for there to be any discussion or interrelationship, or alignment between what was happening with compensation in the Community Health Centres for those positions and what was happening with respect to the compensation of midwives.[648]

---

645 Testimony of Sue Davey, Transcript, October 21, 2016, at p.194 - 195.

646 Testimony of Sue Davey, Transcript, November 1, 2016, at pp.13 - 14.

647 Testimony of Sue Davey, Transcript, October 21, 2016, at pp. 20 – 21.

648 Testimony of David Thornley, Transcript, December 1, 2016, at p. 128.

L. No process for Determining When or How Midwifery Compensation Assessment occurs

971. Midwives have been frustrated for years regarding the lack of process to know if, when, and how compensation evaluation would occur. Initially, the midwives requested a process to fulfil their understanding of the agreement with the MOHLTC regarding COLA:

"we simply took the Consumer Index and looked at our cost of living adjustments over the previous six years, as is stated here, and we presented to Sue Davey our interpretation of what that would mean in terms of midwifery compensation and what we thought was owing us.… for us going to the COLA was so basic, it wasn't asking for an increase in compensation. It was asking, basically, to just keep up with what we felt was fair compensation for midwifery. It doesn't even begin to look at a comparator with the CHC physician, nor the CHC primary care nurses/nurse practitioners. It was really an exercise in good faith with the government to see if they were going to simply agree to the conditions of our framework documents.[649]

972. Ms. Bridget Lynch testified to the MOHLTC's insistence that a new contract framework needed to be drafted, and compensation review could not occur until afterwards.

A. …"we hadn't had an increase and since we were doing a revision of the overarching funding framework, was this now also an opportunity to take a look at the compensation levels, because there had not been a COLA increase, there had not been any increase, and it was obvious at that time that this would be an opportunity to look at the actual compensation levels.

Q. And what was the response?

A. The response was no, and it was categoric.

Q. Was there a reason given?

A. That we needed to get through this framework, and after the framework had been completed, then we could take a look at the compensation levels."[650]

973. Ms. Davey testified to the lack of process for determining if and when COLA adjustments would occur:

Q. Ms. Kilthei had talked about the process at some point of actually revisiting what the level of compensation was. Did you understand that that was part of

649 Testimony of Bridget Lynch, Transcript, September 22, 2016, at p. 218 – 219.

650 Testimony of Bridget Lynch, Transcript, September 22, 2016, at p. 201 - 211.

what you were discussing…during your work group for having a process for revisiting the level of compensation subsequent to regulation.

A. I don't recall those conversations but it was certainly felt that we were not in a position to bind ourselves to a time frame at that point for when we would revisit…

Q. And did you understand then that the COLA was actually a way to ensure an automatic adjusting of the compensation over the period of time so that it didn't erode even if you didn't increase it?

A. We didn't discuss COLA and having COLA as an ongoing integrated part of our budget process… –[651]

974. Ms. Elana Johnson testified to the renewed optimism that the AOM had in 2007 following a commitment from the MOHLTC to engage in a regular process of negotiations:

starting December 2007, and in discussion as well, there was agreement from the OMP that regular review would be a good thing. So we were feeling reassured. [652]

975. Ms. Katrina Kilroy testified to the continuation of the vacuum of process in the MOHLTC's midwifery compensation setting:

this was a real example of how fractured the process felt for midwives, that the proposal to evergreen a contract which, in essence, meant it rolled over year over year, we were assured by the Ministry would -- we would still be provided opportunities at a forum like MCFAC to discuss improvements and changes, but without an end date and because of the history of having so much difficulty getting a negotiation table with the Ministry, we had a very strong reaction to this idea that the contract was unilaterally evergreened. So that's just kind of the frame around what this period of time meant to us or felt to us".[653]

976. MOHLTC witnesses testified to the lack of structure, mechanisms, policies and processes to determine when compensation assessments should occur.

977. Ms. Davey testified about how she monitored midwifery compensation:

Q. what was your system for monitoring the comparable professions to ensure the midwifery scale remained in line with them?

---

651 Testimony of Sue Davey, Transcript, October, 2016, at p. 25.

652 Testimony of Elana Johnson, Transcript, October 5, 2016, at p. 245.

653 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at p. 175 – 176.

A. There really wasn't a formal system. It was really just keeping an eye on the landscape, and making sure that we were familiar with what was going on within the health care system. It was not a formal –

Q. And why wasn't there a formal system?

A. -- monitoring process. We didn't feel that we needed a formal process.

Q. My question was why didn't you feel it was necessary?

A. I can only say that we were quite familiar with the changing compensation within CHCs and within primary care itself, and no further monitoring was really necessary.

Q. It's not necessary because you're familiar with it?

A. Because we were involved with [the midwives] and familiar with the compensation in Community Health Centres and with other primary care providers. So having another process really wasn't necessary.

Q. But we know, Ms. Davey, that for the next five years, no compensation changes for the midwives […]

A. There isn't a formal process in the Ministry for establishing when -- there was not a formal process for establishing when midwives would get another increase.

Q. I understand you're saying there wasn't one. I'm trying to understand. You've told me it wasn't necessary. That's the problem I'm having. I appreciate you didn't have one. I don't understand why it wasn't necessary, given that it left midwives with zero way past the time their comparators were being changed.

A. I don't think it was far past the time when comparators were changed, and certainly, once comparators were, had been changed and once we had some evidence upon which to base our request for increased compensation, we moved forward with the request for compensation increases.[654]

978. Ms. Davey acknowledged that there was no time frame for the review of midwifery compensation:

Q. So, your other note on the first page of that letter at tab -- the November 1st, 2000, letter says: "Will be put on list of changes to be contemplated when the contract is reopened for revisions."…And when was that to be?

A. I don't think we had a time for when that was going to be. But I think what this is getting at is that, if we were going to do anything related to COLA, we would have to -- and doing that was increasing the fixed component of the course of

654 Testimony of Sue Davey, Transcript, November 1, 2016, at pp. 13 – 15.

care over time, that you would have to make changes to the contract. And what I was suggesting was that let's wait until we're making lots of changes to the contract, and one of those changes we might consider would be an increase for midwifery services, but to do that at a time when we were already making changes to the contract." [655]

"Q. I'm just trying to understand when it's open for revisions, is there a term to the contract at this point? As I understood it, you said it started April 1, 2000. So, we're now at November 1, 2000. When did you think it was going to be reopened? And I'm trying to figure out is this an annual?

A. No. It's an evergreen contract, and it's in force until it's changed.

Q. So, how would you -- so, you mean the Ministry could control when it was changed?

A. The Ministry could control when it was changed, and we chose to always consult with the AOM when we did that.

Q. So, the only change to the contract then, that happened after this, happened in 2005?

A. I don't know if there are other changes that were required between that time frame, but certainly any major change to the contract happened not until 2005. [656]

979. The testimony of Ms. Davey also revealed that there was no plan or intention to ensure midwives' pay was equitable because the program had not submitted a request for COLA funding:

*Q… your [*January 10th, 2001] *letter starts off with saying after you thank for the letters that: "Unfortunately, the midwifery program must decline your request for an increase in the fee per course of care for midwives at this time. Currently, the funding allocated to the midwifery program is fully committed to existing services." So, can we just go back to what you were talking about the budget? So, when you say it's fully committed, what do you mean?*

A. It means that there is no money within the vote to -- there is no available money within the vote to use for a compensation increase for midwives.

Q. And as you've described, if you were to obtain money, you would have to make a request for it?

A. Yes.

---

655 Testimony of Sue Davey, Transcript, October 21, 2016, at p.187 – 188.

656 Testimony of Sue Davey, Transcript, October 21, 2016, at p. 188- 189.

Q. But there was a decision made, I think you said at that time, that there wasn't any appetite to get a COLA increase?

A. That's correct.

Q. All right. So, no request was made in those years?

A. We certainly didn't put forward a business plan request, no.

Q. All right. And is it fair to say then that between the time of this request, from the request from November to January 2000 to January 2001, until the decision is made in the fall of 2004, there was no request made by you or anyone else in the Ministry to obtain more money in your budget for compensation? So, we're talking January -- November --

A. For compensation, no, that's correct." [657]

980. Ms. Davey testified that that the original agreement included a provision for COLA but there was no consideration by the MOHLTC to make good on this provision:

Q. …We know that the Framework Agreement in September '93 included …that there would be a COLA adjustment from time to time as determined by the Ministry of Health.

A. Correct. That's right. […] in the beginning, no, there was no consideration of putting in a COLA agreement at the beginning, no. [658]

981. This lack of process existed despite Ms. Davey's testimony that "it's reasonable that the midwives could expect that the Ministry might consider COLA from time to time..."[659]

M. MOHLTC had Policies and Processes in Place to Assess Physician Compensation

982. Hay Group principal Moshe Greengarten testified that they undertook a compensation review report for the AOHC, funded by the MOHLTC for the positions in the Community Health Centres. In this report, Hay included a job evaluation analysis using the Hay system. [660]

983. Mr. Greengarten testified that he recalled there was a schedule of rates that the MOHLTC had of approved salary ranges, and that the schedule of approved

---

657 Testimony of Sue Davey, Transcript, October 21, 2016, at pp. 192 - 193.

658 Testimony of Sue Davey, Transcript, October 21, 2016, at pp. 17 - 18.

659 Testimony of Sue Davey, Transcript, October 21, 2016, at p. 19.

660 Testimony of Moshe Greengarten, Transcript, October 13, 2016, at p. 40.

salary ranges did not reflect the pay equity adjustments undertaken by the CHCs. He testified that it was " was our understanding that it was a separate process, and that CHCs were receiving funding to address the pay equity gaps."[661]

984. Dr. Price testified that the MOHLTC has a strategy in place with regard to physician compensation:

Q. But, in general, the Ministry is attempting to position the physicians' pay in Ontario so that it attracts people here?

A. Yeah. You want to -- or at least stabilizes it.[662]

N. MOHLTC Unaware of How Lack of Gender Inclusive Impact Assessment Policies and Processes Allows Systemic Discrimination to occur

985. Ms. Kilroy's testimony provided the Tribunal with the midwives' perspective of trusting there would be a process, waiting for a process, and then coming to understand the impact of having no process available to the midwives and that MOHTLC would not provide one:

"…to be told for a decade there won't be money for compensation because the money is going into growth, to me, I would just say it's not really acceptable…the way it was being presented to us as a rationale for not being able to have a compensation increase, it didn't appear that the growth had been built into government planning. Like, clearly, when you're growing a profession, we're going to grow it up to some point where the graduating class equals attrition and, you know, maybe that will be in 10 or 15 years. I don't know exactly. Attrition rates may change as the profession gets older.

But to see that the -- and read the affidavits of the Ministry people like we had to go and fight this case for growth, and it had to go back to the Treasury Board and, you know, different things, I mean, I feel for them. They are working really hard to make sure there is jobs for these graduates, but how is it that that's a surprise? How is it that that isn't part of the planning or is it part of the planning? Like, did it actually happen that it's like, well, we're just going to grow the profession for decades and there won't be any increases in compensation for people who are doing the frontline work? I'm puzzled by it. I'm puzzled by it. I don't understand it as a rationale for why we can't fairly pay the people, the women who are doing the work.[663]

I think we still really believed that it was just a mistake, that they just hadn't had the time or attention. They were telling us we have to negotiate with the doctors.

---

661 Testimony of Moshe Greengarten, Transcript, October 13, 2016, at p. 48.

662 Testimony of Dr. David Price, Transcript, April 4, 2017, at p. 154.

663 Testimony of Katrina Kilroy, Transcript, October 6, 2016, at p. 25 – 27.

We'll get to you. We have this big contract. So, we'll get to your smaller contract later. And I think there was a level on which we internalized that and we really believed that to be true…

"we came out of that negotiation with a commitment to a compensation review that looked at scope and working conditions and all the things that we knew were part of a pay equity framework. We didn't go in demanding a pay equity process because we knew legislatively that applied to employees and this structure we were in, we were not employees. But we went in wanting to get some kind of process that would look at those questions, that would …help the Ministry to see that something really unfair was happening here and that they needed to pay attention to it because it was going to, you know, be problematic if they didn't. So, I think even at that time, when we were at the table…we were devastated when they came with their 2 and 2 and 2 percent. We couldn't believe it.[664]

986. Ms. Davey testified:

Q. So, in your handling of the program, is it fair to say that you didn't ever consider how the structures and systems which paid for physicians were delivering higher compensation to them than the structures and processes which were delivering compensation to midwives, did you ever make that kind of an analysis?

A. It's certainly obvious that physicians earn more compensation than midwives and they do a different kind of business than midwives.

987. Ms. Davey went on to testify that the CHC physicians did different work than the midwives, but that the MOHLTC's only evaluation of the differences in the work was "in the job evaluation when we set up the funding for compensation for midwifery" and then such an evaluation was never done again.

988. This lack of a process for further analysis means that the MOHLTC had no basis for knowing based on gender inclusive and evidence based analysis what the appropriate relative positioning between those professions was because the MOHLTC never analyzed it. Ms. Davey testified to this: "No, we didn't. We didn't analyze it again."[665]

O. MOHLTC Improper Use of Gender Biased Market Based Compensation Analysis

989. The MOHLTC also relied on the labour market conditions to allow for an exception to equitable pay. However, Mr. Greengarten in his testimony cautioned strongly against this, as a best practice, and to ensure the appropriate policies are in place:

---

664 Testimony of Katrina Kilroy, Transcript, October 6, 2016, at p. 19.

665 Testimony of Sue Davey, Transcript, October 21, 2016, at pp. 50 - 51.

… we advise our clients to use this, this approach on a very restricted basis; that is to say, we have advised in terms of creating policies that they should have internal policies, that these policies should be put in effect so that jobs, such jobs, first of all, should be a very small minority of jobs. Number two, they should be reviewed on an annual basis to ensure that -- sorry, number two, there should be, there must be documentation as to the reasons for establishing a market exception, and these exceptions should be reviewed on an annual basis to ensure -- to determine whether the conditions continue to exist."[666]

990. The MOHLTC has not reviewed this "exception" and does not appear to have any such policies in place as recommended by Hay.

P. MOHLTC Reliance on Gendered Recruitment and Retention issues,

991. Ms. Naylor testified to the use of recruitment and retention issues as a prompt to undertake a compensation review:

Q.… I'm just trying to understand whether there is any overall systems or policies or practices kind of at a macro level in the Ministry which are trying to sort out that there is some kind of equitable compensation with respect to the providers of the Ministry's health care services?

A. Right. You know, so generally, you know, it is something that we pay attention to. So, the general public sector bargaining environment conditions us, but within the health care sector, we would look at the outcomes of collective bargaining as a pattern setter, as basically a threshold or a referral -- a referral benchmark, for example. We would look at data and evidence around recruitment and retention challenges.…But, you know, it is fair to say too that, you know, all the different forms of providers do pay attention to compensation changes in other professions that they consider reference points or benchmarks. So, it is the hydraulics of how sector compensation across different forms of providers is something that we're always monitoring and the system is monitoring and bringing to our attention. There is a significant area of focus.[667]

Q. MOHLTC Failure to Get Midwives' Compensation "Back in Line' While Aligning Physician Compensation

992. Ms. Davey also testified that the work of a midwife was never analyzed again after the regulation compensation setting process:

Q. When midwifery is regulated, we actually look at the skills, effort, responsibility and working conditions of the midwife and the CHC primary care nurse and physician, but as I understand it now from your argument, after that,

[666] Testimony of Moshe Greengarten, Transcript, October 13, 2016, at p. 147

[667] Testimony of Nancy Naylor, Transcript, November 3, 2016, at pp. 77– 78.

there's no need to do it because you've got enough midwives, they're in the right places, so we don't analyze their work anymore.

A. There was not a call for or a need to analyze the work of a midwife again, no. No, there wasn't.

Q. And that was because you had enough people doing the work? In other words, the relative positioning didn't matter because, based on the respective work, because you had midwives who would still work for you at the rates you were providing?

A. At that time, yes, that's correct. There was not a shortage, there was not a shortage of midwives. There was not a high attrition rate in midwifery at that time, and so there was not seen to be a need for, nor was there the rationale for, to put forward a strong case for increasing compensation.

Once the CHCs were -- once the CHC staff's compensation was increased, then there was more need to then look at midwives and turn our minds to midwives, conduct the program evaluation, and then move forward with a request for increased compensation to bring them back in line.[668]

993. So Ms. Davey understood that there was a need in relation to midwives' compensation, once the CHC staff's compensation was increased to "move forward with a request for increased compensation to bring them back in line". In other words, that there should be an "alignment process". Ms. Davey as head of the Community Health Branch was already engaged in a complicated and time consuming process with the OMA to align equitably the compensation of CHC Physicians with other primary care family physicians funded by the MOHLTC. [669]

994. Relying primarily on these three triggers allows for gender discriminatory influences to enter into compensation setting. For example:

(a) stakeholder pressure from the larger male dominated OMA will always be larger and more dominant that that of the female dominated midwifery association, which is much smaller in large part due to the historical suppression of midwives by male physicians.

(b) Reliance on recruitment and retention issues without any evaluation of the work or analysis or set of gender inclusive analysis principles, reinforces gender bias because there is no objective way to assess for systemic discrimination, and no mechanism to ensure compensation provided to address these issues remains equitable. Recruitment and retention issues may be as a result of market forces which inherently have gender bias built into those markets.

---

668 Testimony of Sue Davey, Transcript, November 1, 2016, at pp.44 - 46.

669 Testimony of Sue Davey, Transcript, November 1, 2016, at pp.45 - 46.

R. There Should be No Need to Campaign and Demonstrate for Pay Equity

995. Ms. Davey testified to the reliance on stakeholder reaction as a method of prompting a review of compensation:

Q. What did you understand was the role of stakeholder reaction in trying to get some objective carried out in government, because as we go along, the stakeholder reaction becomes increasingly negative to the point to which there's demonstrations. There are a variety of things that are happening. Is there some particular amount of reaction that's required to get something done?

A. I don't think it's quantifiable, but I would certainly say there's -- that stakeholder reaction is a key component often to increasing the priority that's given to that particular issue.

Q. … And so, in fact, from the perspective of the midwives then, it was actually necessary for them to demonstrate and become increasingly agitated about their position.

A. Well, certainly, that was effective in this particular case.

Q. … this gets us back to the issue of what kind of systems and processes the Ministry had in place that perhaps would have not necessitated that kind of demonstrating and whatever, if it actually had been just a practice in place, policy in place which would have aligned their compensation. Do you agree with me that that might have been a more, from a public policy point of view, a more effective way of dealing with the issue?

A. It was not a priority for the Ministry to do so.

Q. To have a policy.

A. For increasing compensation, that's correct.

Q. All right. So as a result, it ended up having to deal with demonstrations.

A. That's correct." [670]

996. However, Ms. Davey testified that the male dominated physician group did not need to demonstrate; that is, the lack of policy did not disadvantage the more dominant and privileged physician group:

Q. All right. And at this point, I didn't see the CHC doctors out demonstrating, so they had the Medical Association operating on their behalf with the Ministry?

A. Yes, that's correct. That was -- yes.

---

[670] Testimony of Sue Davey, Transcript, November 1, 2016, at pp. 61 – 62.

Q. So I guess they didn't need the demonstrations to get their pay increased.

A. Well, they didn't demonstrate."[671]

997. Ms. Davey testified to the role of government priorities in the setting of compensation:

Q. …can you point me to any rules or guidelines that you would look at in order to accomplish that, other than, "Here's this amount of money. Divide it up"?

A. I think that the rules would have been in the Ministry's priorities, so what are the Ministry's priorities for this year and how are we going to accomplish those priorities, and if we were able to provide a rationale for including a compensation increase for midwives within the Ministry's priorities, that would have moved forward and so it didn't move forward until it was part of the priority." [672]

998. As there was no gender inclusive human rights equity lens used to determine MOHLTC priorities, leaving the matter to the "Ministry's priorities" disadvantaged the vulnerable midwifery group.

A. And at this particular time in the midwifery program history, we were moving forward with increases quite regularly for the midwifery program [for program growth]. It became difficult to justify for the Ministry to take on a request to go to Management Board that would increase the funding for expansion of the program, increase the funding to fund the liability insurance, and then also increase the funding for compensation. The Ministry was not willing to do all those things at the same time.

Q. But, in fact, they did do all those things for the CHCs. They expanded.

A. And in the end, that is also what we did for midwifery, but that was in the face of having evidence to support that. The same with the CHCs. We were addressing the need, a recruitment and retention need in the Community Health Centres. It took 10 years for the CHCs to get an increase in their salary. It's not a perfect system, but once the need is identified and the rationale is there and it fits within the Ministry's priorities, then it moves forward to the next step.

Q. And in terms of the Ministry's priorities, just so that I can understand this, I think you've told us before that a kind of a gender-based analysis was not part of the government's priorities in any of the period of time that you were there?

A. That's correct.

---

671 Testimony of Sue Davey, Transcript, November 1, 2016, at p. 62.

672 Testimony of Sue Davey, Transcript, November 1, 2016, at p. 67.

Q. All right. And let me look at this another way as well: Under the Pay Equity Act, for example, which was having adjustments that we've seen in the Hay reports, in the CHCs, those adjustments were just being funded because they were legally required. Is that it?

A. They were funded because they were being legally required, yes.

Q. Okay. So certain obligations are funded because they are legal obligations, but others that are discretionary, it has to be a priority in order for it to happen. Is that a fair way of putting it?

A. I think that's fair.

Q. ...Is there any linkage in your understanding in the Ministry, well, let's just say first in relation to your branch, between your branch and the Ontario Women's Directorate providing any advice to the branch, your branch, or alternatively to the Ministry itself when it's making its decisions?

A. I don't recall that.[673]

999. Relying on MOHLTC political dynamics to determine compensation is highly subject to gender bias: the bureaucracy, political staff and the politicians themselves may not be invested in ensuring women have equity in their pay; the politicians may face an electorate that may not support women having the human right to equitable pay; and the issues of the day may not have any type of gender lens brought to them.

S. Different and Systemically Unequal and Disadvantageous Compensation Processes Afforded to Midwives and Physicians

1000. Without processes, policies and systems in place, different treatment of the midwives, compared to the physician group, became routine in the setting of their compensation. The midwives and the CHC physicians were afforded different processes in their compensation setting; most often, the midwives were offered no process at all.

1001. Ms. Ejiwunmi testified that the MOHLTC insisted a program evaluation must be completed before a compensation review could be undertaken.[674] Ms. Davey's testimony supported this:

What I had said to the AOM was that we need some rationale to support a request for compensation increase, and one of the steps in creating that rationale would be to show that the program is doing what it's supposed to be doing and achieving good outcomes and being effective and it's sustainable, and so yes,

673 Testimony of Sue Davey, Transcript, November 1, 2016, at pp. 67 – 72.

674 Testimony of Remi Ejiwunmi, Transcript, September 28, 2016, at p. 43 - 44.

that, having that along with our request for compensation was more likely to make that something that would be approved".[675]

1002. Although the CHC sector conducted a strategic review, the CHC physicians were not subject to a program evaluation to demonstrate their outcomes prior to a compensation review.

1003. The CHC physicians had a compensation review paid for by the MOHLTC, whereas the midwives` request for the same support and process was refused. Ms. Davey and Ms. Ejiwunmi both testified to the very different treatment by the MOHLTC towards the two compensation reports by the Hay Group. The MOHLTC paid for the AOHC report, and used it to provide significant increases to the physicians. However, the MOHLTC refused to pay for the report commissioned by the AOM, causing the small association to scramble to find resources to pay for this critical document; then the MOHLTC dismissed its methodologies and did not take it into account in any analysis of the midwives' compensation[676]:

…we had actually found out that the Association of Ontario Health Centres had had a compensation review funded by the Ministry of Health and Long-Term Care, and so we had gone to the Ministry and requested if they would fund a compensation review for us, and we were told that they would not cover the cost… if we wanted to undertake a compensation review, we would have to fund that ourselves. And so the discussion was around how we were going to use a line of credit or other sources to be able to pay for that compensation review.[677]

1004. CHC physicians were provided with a process of alignment to ensure fair and equitable pay across the primary care sector. Midwives were not provided with the same alignment process, despite the fact that the alignment exercise as occurring within the same sector*:*

Q. What would have been so difficult, while you were aligning the CHC physicians with their peers, to align the midwives with the CHC physicians at the same time? Seems to me that would have been fairly simple to do.

A. Well, the alignment was about aligning practitioners within the same profession. That's what alignment was about. It wasn't about aligning other providers with physicians.

Q. Well, we'll go through the documents because the documents talk about aligning primary care providers and you'll agree with me that a midwife is a primary care provider.

---

675 Testimony of Sue Davey, Transcript, November 1, 2016, at p. 74.

676 Testimony of Sue Davey, Transcript, November 1, 2016, at pp. 88 – 98.

677 Testimony of Remi Ejiwunmi, Transcript, September 29, 2016, at p. 55.

A. Midwives are primary care providers.

Q. And a number of the documents talk about that the alignment process was aligning primary care providers.

A. Well, certainly, the emphasis of the exercises that we were participating in was aligning physicians.

Q. Well, I understand that the midwives got left out of your process. What I'm asking you is, why would it have been so difficult at the same time great effort was taken to align the CHC physicians, why couldn't you have just aligned the midwife at the same time?

A. That's not what the exercise was about.

Q. I'm asking you why you couldn't have done it, other than people didn't want to.

A. It was an exercise to align physicians' salaries. It didn't come up to align other practitioners with physicians' salaries. That was not part of what we were doing.[678]

1005. Ms. Davey agreed that physicians were provided with an extensive process to determine appropriate and fair compensation; midwives were given a lump sum amount without the benefit of analysis about how they should be aligned[679]:

Q. So, in essence, the CHC physicians had -- were provided with an elaborate process for aligning their compensation, and the midwives were told they had a certain amount of money and they had to divide it up.

A. Yes, that's correct."[680]

T. Rural Incentives Applied Unequally to Midwives and CHC Physicians

1006. The CHC physicians were assessed and incented to work in rural and remote areas; the midwives were not informed that the CHC physicians had received such incentives, and were not offered such incentives to provide service in similar communities where there was a shortage of obstetrical providers:

1007. Ms. Davey in cross examination testified as follows:

---

678 Testimony of Sue Davey, Transcript, November 1, 2016, at pp. 58 – 59.

679 Testimony of Sue Davey, Transcript, October 21, 2016, at pp. 33 – 34.

680 Testimony of Sue Davey, Transcript, November 1, 2016, at p.60.

Q. And Ms. Kilthei has testified that they were never advised that there was a different payment grid for the rural or underserviced areas; would that have been consistent with your understanding of this chart from Mr. Morton?

A. Certainly we did not include the underserviced rate for physicians when we were comparing… The underserviced rate for physicians had been put in place because of an identified shortage of providers and so it was an incentive to -- it was part of the Ministry's incentive for encouraging physicians to practice in remote locations.

Q. And wasn't it also an objective of the Ministry to get midwives to work in underserviced areas where there weren't enough obstetrical providers?

A. It was an interest of the Ministry certainly to increase the number of obstetrical care providers but we didn't, for a number of years, enforce where midwives went for the first -- for the first few years. But, yes, when we were allocating midwives across the province, we tried to look at equitable distribution across the province and tried to address underserved areas as well. But in the funding of midwifery, every...every part of the province was underserved for midwifery.

Q. I see. So, if you were trying to, therefore, increase the access of midwives, all of them would need to be -- people would be encouraged to be a midwife in every area of the province, is that it?

A. There wasn't really any need for an extra incentive for midwives to practice. We were setting up a profession and there were lots of midwives wanting into the regulated system and into the funding system, and there were lots of new students lining up to be in the program. There wasn't a need for any kinds of different sorts of incentives for midwives to practice in the program."[681]

U. MOHLTC Relied on Speculation and Ignored Evidence

1008. The MOHLTC has a history of ignoring and dismissing evidence that could inform the compensation setting of midwives. They have also shown this pattern with nurse practitioners, another vulnerable female-dominated group:

Q. …are you relying on any analysis of the nurse practitioner to come to this conclusion?

A. No, I don't think so.

Q. Okay. So this is just kind of a ballparking, that you think they must be more comparable to the nurse practitioner?

---

681 Testimony of Sue Davey, Transcript, October 20, 2016, at p.15.

A. I think this is saying they're more the same than different […]

Q. And at this point, you actually haven't done any analysis, right?

A. That's right.[682]

1009. The MOHLTC showed a lack of disregard for the report of Hay and Courtyard, despite the fact that they relied on Hay to assist with their compensation analysis of the CHC physicians, and had fully participated in the procurement, management, data gathering and analysis of the Courtyard report:

A. Certainly, the discussions were moving along quite favourably about -- between the midwives, the Association of Midwifery, the Ontario Midwifery Program, and the government at that time, and it was certainly progressing in a positive way.

Q. But that was when you got the Hay report in July. So I'm not quite understanding why it wasn't relevant to your discussions if you were having --

A. Well, we were certainly telling the Minister that the Association had given us a Hay report.

Q. Yes.

A. And that this is what the Hay report had recommended, but we weren't making any recommendations based on the findings of the Hay report.[683]

1010. This unequal approach to compensation setting adversely impacted the midwives. While the MOHLTC agreed to set the compensation of CHC physicians at the same amount recommended by the July, 2003 Hay report, the MOHLTC ignored the Hay 2004 report that the midwifery compensation be adjusted. The MOHLTC also ignored the Hay Report's additional recommendations to collapse the 12 steps into one job rate and to regularly monitor the midwives' pay.

1011. The MOHLTC deliberately decided to ignore the Hay evidence based analysis of the midwife and the CHC physician and instead to rely on an uninformed analysis. Ms. Davey demonstrated this approach to the setting of midwifery compensation in her testimony:

Q. So was that a reflection of how much you thought you could get or a reflection of what you thought the job was worth?

---

682 Testimony of Sue Davey, Transcript, November 1, 2016, at pp. 89 - 90.

683 Testimony of Sue Davey, Transcript, Nov ember 1, 2016, at p.100.

A. It was set based on comparing to the physicians and the nurses and the nurse practitioners, and was felt to be a fair compensation for midwives and felt to be something that could be defended and supported. So it was a bit of both, I guess.

Q. But there wasn't actually any analysis of the work done that I saw from those documents.

A. We'd done an analysis of the work of midwives in 1993. We did not repeat that at this time.[684]

V. MOHLTC has No Policies to Ensure *Human Rights Code* Applied and Enforced

1012. Ms. Naylor testified that she was not aware of policies or practices that in place in the MOHLTC that sets out how to ensure that the MOHLTC is in compliance with the *Human Rights Code*, but rather the staff solely relied on MOHLTC legal counsel to flag issues:

First of all, virtually all policy submissions or recommendations of the government are formulated with the advice of legal colleagues. So, our Legal Services Branch colleagues in the Ministry of Health, MAG, who are MAG, counsel to MAG, so they look at virtually everything we produce, whether there is an apparent legal dimension or not and, you know, that's...that's good discipline for us to have because sometimes program analysts don't recognize a legal obligation, whether it's code, whether it's constitutional….

Subsequent to that, if anything that we're doing or bringing to Cabinet needs legal drafting or the participation of legislative counsel, the Ministry of the Attorney General reviews all pieces of legislation or regulations. And if there is any doubt about the constitutionality of the drafting, which is done at the direction of the Ministry, if there is any doubt, there is a convention that the regulation or the piece of legislation is left unsealed. So, there is a convention. It goes back to the dawn of time that that material arrives in Cabinet with a black corner, a tab on its -- on the actual documents that is black-cornered. So, if there is any doubt about the constitutionality, the terminology is, you know, MAG or leg. counsel will refuse to black corner a regulation or draft, legal drafting. So, it's a very strong signal. It is an unmistakable signal to the government that they may be considering an item that is subject to legal challenge.[685]

1013. This approach assumes that any discriminatory action is one that would be documented and therefore would come to the attention of the MOHLTC legal counsel. However, in the case of the midwives the lack of action is part of the

---

684 Testimony of Sue Davey, Transcript, November 1, 2016, at p.179.

685 Testimony of Nancy Naylor, Transcript, November 3, 2016, at p. 208 – 210

pattern of systemic gender discrimination. The lack of action may not prompt the type of paper trail that Ms. Naylor is referring to, and therefore, the MOHLTC legal counsel may be oblivious to the Code violations that stem from a lack of action.

1014. Ms. Pinkney testified that

(a) she never considered with the midwifery compensation and funding was in compliance with the *Human Rights Cod;.*[686]

(b) she never considered whether or not any compensation adjustment for midwives was exempted from the compensation restraint laws or policies because it was a right or entitlement under the *Human Rights Code.*[687]

(c) there was no human rights policy in place that might have led Ms. Pinkney to any kind of analysis about whether they had any Human Rights Code entitlement;[688]

(d) it did not occur to her that in all of the actions that she was undertaking here that she was violating the Human Rights Code;[689]

(e) there was no kind of analysis undertaken that would give assurance that the MOHTLC was in compliance with the Code;

No, nothing specific was undertaken…we had no reason to believe that there was any human rights issue that was occurring with regards to the payment…In terms of the discussions that we were having, it was never, never raised as an issue that there was any human rights -- any concerns with regards to human rights payments that were being made for -- under the midwifery program. It wasn't an issue that we had looked at or had had raised";[690]

(f) she was unaware of any specific steps that were taken to ensure actual compliance with the Code as opposed to assuming compliance because there were no complaints received: "We continued to operate and deal with the program the way we had always been administering it";[691]

---

686 Testimony of Laura Pinkney, Transcript, December 2, 2016, at pp. 35 – 49.

687 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 35.

688 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 35.

689 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 38.

690 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 39.

691 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 40

(g) she had never undertaken a Human Rights Code analysis with respect to a transfer payment;[692]

(h) she had never done any kind of analysis of that in your Results Based Planning (RBP) budgetary processes, with respect to the midwives, in respect to the Code and whether or not there was any kind of risk or impact, depending upon the decision, with what was being put forward in the plan with respect to funding for the midwives[693]; and

(i) the midwives claims that they were making about inequities in their pay was never flagged as a potential risk as a Human Rights Code violation in the RBP process.

1015. Ms. Pinkney also testified about the lack of processes and policies to ensure equitable treatment towards midwives as the Ontario government was striking more favourable compensation packages for male dominated groups such as the OPP, physicians and Corrections workers:

Q. The doctors, the OPP, its own employees. There are a series of people who it's negotiating with. Did you have any process in place to make sure that the negotiations you had with the midwives had some kind of equitable process that took into account what you were doing in these other negotiations? So, for example, if you, the government, as we know it did, negotiated with the OPP this spring-back proposal, which the midwives talked about as being for a male-dominated workforce, the OPP, did you consider in relation to that what you should be doing and what impact that would have on midwives?

A. We did certainly attempt to look at what was happening in other sectors, and as I said, gather information with regards to what might be possible in terms of an offer that we could make to the midwives.

Q. And so what information did you gather that allowed you to kind of equitably assess the offers made in other jurisdictions in relation to the midwives? What specifically did you look at?

A. We would have looked at just what was happening across other sectors and trying to draw comparisons to see what, as I said, what sort of increases were being proposed, in particular, looking at the third year of the agreement, and had some discussions with regards to what would be considered possible and appropriate under the current fiscal constraints [694]

692 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 45-46

693 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 47-48.

694 Testimony of Laura Pinkney, Transcript, December 2, 2016, at pp. 32 - 33.

1016. And yet, the MOHLTC did not use the CHC physicians as the comparator for midwives. The MOHLTC did not use out of province jurisdictional comparisons when they assessed the compensation of physicians.[695] However, the MOHLTC did use an out of province jurisdictional comparison for midwives, starting in 2010, despite the fact that there is no policy to this effect requiring it:

…the AOM certainly flagged the Morton report and, subsequently, the Hay report, and drawing distinctions between how the initial Morton report had been used in terms of trying to determine an appropriate salary to start with. From the position of the Ministry, by the time we reached into the mid 2000s, we're actually also looking at the fact that other Canadian jurisdictions have established midwifery funding and midwifery programs, so also starting to take into account where midwifery funding aligns in terms of Canadian jurisdictions. [696]

W. MOHLTC's lack of awareness and training in equity, systemic gender discrimination and the Code

1017. The MOHLTC witnesses frequently showed an astonishing lack of knowledge and awareness of the issues of gender equity, the *Human Rights Code*, and systemic gender discrimination.

1018. MOHLTC witness Laura Pinkney testified that:

(a) she was not familiar with the term "occupational sex segregation" or with the concept of systemic gender discrimination and compensation for women[697];

(b) she was not aware that 80.1% of the health occupations are women;[698]

(c) she had never been trained to identify systemic gender discrimination by the government[699];

(d) had never applied any policy of the government that was aimed at identifying systemic gender discrimination with respect to the midwifery work, funding or compensation[700]; and,

(e) had never had any training, either academically or at the government, with respect to how to do gender-based analysis or human rights-based

---

695 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p. 114.

696 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p.110.

697 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p.54

698 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p. 54.

699 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p.43

700 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p.43.

analysis with respect to a policy as to whether or not a policy complies with human rights, human rights legislation, the Charter. [701]

(f) did not take into account that midwives were almost exclusively women.[702]

(g) did not understand that as a result of the high female predominance of women, that might affect the conditions under which midwives worked.[703]

1019. While Ms. Pinkney did have some human rights knowledge from being involved in a Human Rights Tribunal case brought against the MOHLTC, this did not seem to have any impact on her handling of the midwifery file. [704]

1020. Dr. Chaykowski spoke to the need for policies that would address the complexity of midwifery work. During his testimony, he quoted his article "Women and the Labour Market: Recent Trends and Policy Issues":

A. 'Two key challenges include the ongoing Canadian dilemma of how to develop and encourage policies that make sense across diverse jurisdictions and ensuring that the policies aimed specifically at women workers do compete successfully with other policy priorities.'

What I'm saying here is essentially that, you know, this ought to be a policy priority and that is developing policies that work to the benefit of females in the labour market.

Q. … And in terms of then your next report "Achieving Pay Equity Under a Transformed Industrial and Employment Relations System" … that report discusses the implications for pay equity of having that transformed system so you say from the traditional industrial relations system…

Q. … the bullets that were on Roman numeral (iii) which were talking about applying pay equity to the growing proportion of non-unionized workers and to workers in occupations in which their work was more difficult to evaluate by standard approaches to job evaluation is one kind of example of it.

A. Right. So, this bullet list on this page, including that particular question or issue I stated at the introduction, you know, these are complexities, the evolving labour market and the way it's evolving raises a number of these complexities, and these complexities in turn raise a number of critical issues, one of which is the one that you just cited….And what I'm basically saying is that these critical issues… ought to be addressed…. there's a long continuum of work, not just my

---

701 Testimony of Laura Pinkney, Transcript, November 4, 2016, at pp. 43 – 44.

702 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p.55.

703 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p. 55.

704 Testimony of Laura Pinkney, Transcript, November 4, 2016, at pp. 44 – 46.

own, that speaks to the issue of the growing complexity of work contexts and employment relations, and even in Ontario I think the current workplace review effort, the panel undertaking the….Change in Workplace Review panel… would be another example of that.[705]

1021. Dr. Chaykowski also testified to the need for policies that would address the non-standard nature of midwifery work:

Q. in the context of addressing scope and coverage of pay equity laws… you talk about you need "innovative approaches may have to be devised if the coverage of non-standard workers is to be achieved"…? So, this is in the particular context of looking at what might be in law, right?

A. Well, I'm making this comment in the context of my report specifically to the Federal Task Force that they consider this idea.

Q. … if I can take you to … your Law Review article following these reports called the 'Implications of the Changing Structure of the Economy, Labour Market, and Workplace for Canadian Labour Policy: The Case of Pay Equity'…you're saying:

'The main focus of this analysis is the need to update and modify our traditional approaches to the design and implementation of pay equity as a policy response - given the current need for and efficacy of the policy - in order to offer insights into how both pay equity policy, and other labour policies more generally, may be updated to better reflect the reality of the new economy.…And then … you're saying:

'Pay equity is a policy designed to achieve equity. Governments may simply choose to pursue pay equity regardless of any economic costs, which may be higher under globalization, because society heavily weights equitable pay outcomes. The question is whether or not there are efficiency benefits associated with the policy.'

A…what I am highlighting here is the fact that sometimes, you know, good equity makes for good efficiency, and that even if there are efficiency costs, you know, the social values may be such that you move ahead and pursue and give an equity outcome regardless."[706]

1022. Dr. Chaykowski also outlined how the MOHLTC could address the lack of pay equity policies for

Q. …in terms of again going back to the issue of non-standard forms of employment, those other mechanisms, which would be laws or policies,

---

705 Testimony of Richard Chaykowski, Transcript, March 31, 2017, at pp. 6 – 8.

706 Testimony of Richard Chaykowski, Transcript, March 31, 2017, at p. 39.

essentially governmental laws and policies, what you're saying are the ones that are the more important are a focused framework for achieving better equity outcomes?

A… I would look, for example, at the recent report … produced by [The Gender Wage Gap Steering Committee]…And one of the things that they emphasize is that there is many things that have to happen if we're going to achieve equity. And so certainly they emphasize the role of government and government policies. But they also emphasize, for example, the role of individuals and the role of management in promoting policies that are fair and equitable in their organization… they take I think a holistic approach and I think my read of that report is that they see these as mutually reinforcing when they work properly and they work together, and I think that's a good way to look at it.

Q. …maybe it's another way of phrasing it, of putting pay and employment equity measures together in order to use a number of different measures to attack the pay gap?

A. Well, if we're talking about the overall pay gap, then it will take multiple measures, and that's also something that's clear in that Gender Wage Gap Report that we were just referring to.… there may be valuable lessons that could be gleaned from, you know, how this type of a model [the occupational health and safety model] functions that could benefit, you know, a pay equity model, for example, and this is also all in the spirit that there are many models, potential models, by which one could achieve pay equity. And I think this is well-acknowledged. This is something which, as I recall, Dr. Armstrong herself emphasized that there is more than one model.[707]

X. Lack of Process Contributed to Midwives' Gender Pay Penalty

1023. Courtyard Group principal John Ronson recognized during his project for the MOHLTC that midwives had been seriously disadvantaged by the lack of a negotiations process, specifically the lack of regular negotiations. He stated this in his report "the Courtyard Report" and testified to this:

it appeared to us that one of the reasons that both parties had gotten themselves in this situation was I'll call it the lack of kind of regular negotiation or kind of paying attention to compensation levels and making sure that they were equitable relative to peer comparators. So, we did make a specific recommendation that they should get into some kind of a rhythm of regular negotiations, whatever that might look like. It might not be annually but certainly on a -- on a more regular basis than had been the case in the past.[708]

---

[707] Testimony of Richard Chaykowksi, Transcript, March 31, 2017, at pp. 11 – 13.

[708] Testimony of John Ronson, Transcript, October 14, 2016, at p. 93.

1024. Elana Johnson testified to the exacerbating effect that lack of process and regular compensation reviews had on midwives:

midwives had been held at zero percent for 10 years, and it felt unbelievably inequitable in every way to now say that we would, in any increase to address that gap, which they had acknowledged, George Zegarac acknowledged that gap, and said, "We can't make up for a 10-year gap in the first go round, in one go round," and yet to hold us to that 2 percent when all of those other professions being held to 2 percent had regular incremental increases positioned them in a much different place than midwives were."[709]

1025. Effectively, midwives were penalized with no compensation increases when others such as the physicians and OPP were receiving them, but then were hit twice as hard when the "restraint years" were in force. Midwives like others were held to zero increases, but had already started from far behind others whose compensation was set by the government.

PART 31: MOHLTC FAILED TO INVESTIGATE AND ADDRESS ALLEGATIONS OF INEQUITABLE MIDWIFERY COMPENSATION

A. MOHLTC Late Acknowledgement of Obligation to Investigate

1026. Associate Deputy Minister Nancy Naylor agreed in her testimony that the MOHLTC had an obligation, when gender discrimination allegations were made by the AOM, to investigate to determine whether there was any validity to it*:* "I would agree that the government always had a responsibility to respond and assess any allegation as serious as that."[710]

1027. Ms. Naylor testified that it is the government's obligation to have a process to investigate and an obligation to undertake that investigation:

Q. … at various points you keep saying, well, they didn't ask us or they didn't do whatever, but you're actually the ones who are setting the pay. So, would you agree with me that you're the entity that has to have the process?

A. Yes. We set the pay. And so I would say as we're considering compensation adjustments, if we believe that there is an argument to be made, then we should be investigating that argument.[711]

B. MOHLTC failed to investigate or analyze the link between gender and midwifery compensation

---

709 Testimony of Johnson, Transcript, October 5, 2016, at pp. 38 - 39.

710 Testimony of Nancy Naylor, Transcript, November 3, 2016, at p.171.

711 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p. 39

1028. There was no evidence provided by the MOHLTC witnesses that they conducted an investigation at any time once and after midwives made the link between gender and their compensation. Several MOHLTC witnesses testified that no analysis of whether the Human Rights Code applied to the midwives' situation was undertaken.[712] The MOHLTC also did not conduct any investigation prior to this time, even though the MOHLTC knew that the midwives were an almost exclusively female profession who had been claiming since at least 2000 that they were not paid equitably.

1029. Ms. Pinkney testified that this was true for her entire tenure covered by her affidavit, and apart from the Negotiations Branch and as far as she was aware, no other part of the Ministry or any other part of the government ever conducted such an analysis.[713]

1030. Ms. Scarth testified that she was aware that the midwives' allegations were based in the *Human Rights Code* and not the *Pay Equity Act*.[714]

1031. Ms. Naylor did not provide any specifics to the Tribunal regarding what, if any, analysis was undertaken by the MOHLTC to satisfy itself there was no discrimination in the pay. Ms. Naylor's reply to this question finally was: "what's in the government's evidence in this case is our response that, yes, that any distinction in compensation for midwives relative to comparable health sector professions is a result of occupational status and other factors other than gender."[715]

1032. When asked if the midwives claim of a link between gender and the failure to provide them with appropriate compensation would prompt an intervention by the government, Ms. Naylor responded: "It wouldn't have been the predominant reason. I think it was, you know, the predominant reason would be that they are a valuable part of the health care provider landscape. They are not happy about something."

1033. Ms. Naylor was unable to be specific about how the MOHLTC gave due weight to the midwives' concern about the link between gender and compensation, and how the MOHLTC satisfied itself that there was no link between gender and compensation such that the MOHLTC needed to respond. Ms. Naylor responded to Vice Chair Reaume's statement "The government has responsibility to take that seriously" by stating:

---

712 Testimony of Laura Pinkney, Transcript, November 8, 2016, at p. 123; Testimony of Fredrika Scarth, Transcript, December 8, 2016, at pp. 138 – 141; Testimony of Melissa Farrell, December 7, 2016, at p. 221.

713 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p. 61.

714 Testimony of Fredrika Scarth, December 8, 2016, at pp. 139 – 140.

715 Testimony of Nancy Naylor, Transcript, November 3, 2016, at pp. 171 – 172.

"So, you're right, that is an obligation that we have and we would look at that. I think our view though in looking at the compensation for midwives, including the funding that's provided to support their practice environment, which takes a certain cost away from them, you know, I think there is a view that we feel it's comparable or proportional to the compensation provided by other professionals. There is no one who has the specific scope of practice of midwifery. So, we have to look to comparators and we are always looking at the range of health care professionals who have similar educational preparation requirements, similar scope of practice, number of controlled acts, the practice circumstances.

You know, the uniqueness of midwifery makes it, you know, hard to do an exact comparison. But, you know, we look at other professions to see what they are doing. And, you know, it is probably relevant that, as adjustments are made to the compensation of other health professionals, so the investment in interprofessional care would certainly be seen as a reference point when the government was considering the compensation claims of midwives.[716]

1034. These non-responsive answers by the third ranking official of the MOHLTC is both disturbing and telling.

1035. Ms. Naylor was unable to articulate with any specificity the steps that the MOHLTC took to investigate, analyze and address the allegation of gender discrimination; this should leave the Tribunal suspicious that an investigation took place:

So, an allegation of gender discrimination, you know, would always be taken very seriously by the Ontario government. In this case I would say that I observed that it was not only taken seriously, but it was a source of distress for both Cabinet ministers, senior officials because of the value that the midwife -- midwifery profession, you know, has held. The idea that we would be at odds that seriously with a valued partner was the source of distress and concern, and it was a priority.

So, I spent time on this, my colleagues spent time, my deputy spent time, my Cabinet ministers spent time and a central agency. So, you know, if there is some indication of the priority and the weight that was given to that concern by the amount of senior government attention to it, I can tell you, you know, you could verify my schedule from those days and we spent a lot of time on that issue.

So, you know, that is evidence of the weight that was put on it. I'll exclude legal advice. But, you know, we certainly recommended, you know, positive action in response to it, and we were supported by the government in saying that that was -- that was an allegation or a concern that had to be taken seriously, the Ministry had to spend time on it, the Ministry had to prepare itself to provide a

---

716 Testimony of Nancy Naylor, Transcript, November 3, 2016 at pp. 164 – 165.

constructive response, and to engage, you know, the profession and the leadership of the profession in a, you know, in a constructive environment that, you know, gave weight to that allegation.

So, I am going to stop there to avoid going too far but I hope that gives you some flavour of the weight that was given and the deference and respect that was given to that allegation.

Q. And the result of all of that was the conclusion that sex wasn't a factor in the compensation of midwives?

A. I didn't go that far. I think that's -- that's a matter for this hearing to decide, is it not? That's one of the things that's at issue here.

Q. I'm interested in finding out whether what, and as I've said, what investigation took place after the complaint because normally that would be when somebody makes a human rights complaint, somebody is supposed to investigate it and then either say, yes, that's a problem or, no, it's not a problem.

A. What I can tell you is that was, you know, it was an allegation that prompted a fair amount of analysis developed by the Ministry. It was for me personally an emersion into the history of the program, the nature of funding and compensation decisions that had been made over the years. I participated in briefings of, you know, senior members of the government independently and in committee on the topic. So, it was discussed but, you know, there was a repeated view that midwives were valuable, that we wanted to restore a constructive partnership with them. So, you know, there were events and trajectories that followed from that that are excluded from, you know, today's discussion. But, you know, one of the work streams that arose from that was the positive work that's still going on between the Ministry and the facilitator and the AOM on a new Funding Agreement….[717]

1036. Ms. Naylor was asked about what investigation was undertaken by the MOHLTC when the allegation of gender discrimination was made. Her answer demonstrated a lack of understanding of MOHLTC obligations under the Code:

… fall of 2015, so just over a year ago, one of the first things I remember being engaged in on the file was Minister Hoskins asking us to arrange for mediation services. So, we engaged a mediator and some other resources and entered into quite formal discussions with the Association of Ontario Midwives about the nature of that complaint. So, that involved, you know, a lot of briefings internally. It did involve analysis. So, we did look at the nature of the complaint. We looked at, you know, a range of factors including the history of the program, comparators. There were many, many meetings internally to the Ministry, with other parts of government, both formal and informal, and with Cabinet ministers

[717] Testimony of Nancy Naylor, Transcript, November 3, 2016, at pp. 178 – 181.

who were interested, both briefings and formal decision forms… there was a decision process within government to seek approval for a mandate to engage in that mediation and to engage in it with honourable intent to meaningfully participate towards a solution. [718]

1037. MOHLTC witnesses agreed that no action had been taken with regards to whether there could be an issue of systemic gender discrimination in compensation with respect to the Ministry's funding.[719] The reasons were varied. Ms. Pinkney, for example, testified that negotiations were underway; and the Courtyard report was not a pay equity analysis:

At the time that we were undertaking negotiations, we were looking at the position taken by -- put forward by the AOM with regards to the compensation review report, and not looking at -- we didn't explore the issue under -- I forget how you referred to it. Gender and inequity? Is that the term that you used?[720]

There were questions raised, as I've mentioned previously, with regards to the Compensation Restraint Act and whether that applied to midwives... In addition …there is language in the materials with regards to compensation restraint legislation, and it speaks to pay equity, pay equity payouts not being captured under the Act. And subsequently the AOM also raised the issue of Courtyard then being looked at as a pay equity payout and, hence, being exempt from the -- from the restraint policy. And that also was followed up with the Labour Secretariat. And we did inform the AOM that this Courtyard wasn't a pay equity analysis, and this was not pay equity and the pay equity legislation didn't apply to midwives.[721]

1038. There were attempts made within the MOHLTC to bring forward some kind of response, but none of these were brought forward to the midwives:

The ministry could present the 3% compensation increase as a 2% base increase and a 1% relativity adjustment. However, this may be perceived by the AOM as insufficient to truly reflect a relativity increase that they see as appropriate. Nevertheless, language that recognizes the relativity issue could be included in the agreement as follows: "The compensation increase is a step towards achieving relativity with comparator professions (i.e., nurse practitioners and family physicians)." And was that ever proposed?

---

718 Testimony of Nancy Naylor, Transcript, November 3, 2016, at pp.166 – 167

719 Testimony of Laura Pinkney, Transcript, November 4, 2016, at pp. 47 – 48; Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 102.

720 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p. 48.

721 Testimony of Laura Pinkney, Transcript, November 8, 2016, at p. 123

No, not during my time with the program.[722]

Q. …So one, option 1 is 0 percent, 0 percent, 5 percent, and the con to that is: 'Does not fully address the pay inequities flagged in the 2010 Compensation Report. "AOM may not accept this deal any future compensation review would not be able to ignore the 2010 Compensation Report and therefore the results may not be significantly different.' And what ended up being decided? Was there ever a decision to put forward a new opposite compensation option?

A. Not while I was still with the program."[723]

Q. … 'Michelle Rossi's email is quite clear so work from that using the previous options document - the option is 0, 0, and I would say notionally 5 percent to address pay equity with some contingency that it is informed by a review in the second year to deal with the issues coming out of the first review. I think we probably cap the third year @ 5 percent but may have language that a new agreement would continue to implement any additional equity requirement that exceeds 5 percent.' And I gather that was never actually proposed?...

No."[724]

Q. "the recommendation is: 'Work with Minister's Office to see if there is conditional support that could be provided - for example - we agree that there is a relativity issue but do not agree with the comparators or the range of the differential.'

…'As an alternative could discuss a more formalized dispute resolution process as we have done for OMA. Under that process, the Parties agree on a third party who will seek to find resolution. This provision is in the Appendix of the Agreement but has not been used.' Was that proposed?

Not during my time with the program, no."[725]

1039. The AOM had put forward several options to address the inequity including:

(a) A "trigger" or "me too" provision in the agreement whereby any increases provided to doctors or nurses beyond the government's current compensation offer would result in an equal adjustment for midwives; and

(b) Inclusion of a provision for interest arbitration.

---

722 Testimony of Laura Pinkney, Transcript, December 2, 2016, at pp. 117 – 118.

723 Testimony of Laura Pinkney, Transcript, December 2, 2016, at pp.105 – 106.

724 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p.106.

725 Testimony of Laura Pinkney, Transcript, December 2, 2016, at pp. 120 – 121.

1040. The MOHLTC did not support these requests and provided no rationale to the AOM as to why these options were unavailable. The MOHLTC has now agreed to binding interest arbitration with the OMA to cover physician compensation which would include CHC physician compensation.[726]

1041. After the MOHLTC had received the Courtyard report, the MOHLTC had internal discussions regarding the undertaking a second compensation report:

Q. Then if we go to page 4… it says: 'To date, there has been no public position on the compensation review by the Ministry.' And it says: '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[ed] amount. A second report carries the risk of another 20% recommendation, with additional consulting costs. The government will definitely need to address a second report with similar results as the first.' So that appears to be -- is that the end of any discussion about there being any second report?

A. I don't recall. This is still in draft with regards to the changes, so I don't recall if there were further documents that had additional information about a second report.

Q. But somebody clearly didn't think that a second report had a good chance of coming out with a less recommended amount than the first one.

A. I think this was highlighting that there was a risk…in terms of what may come out of the second report.[727]

Q. ..So at paragraph 2: '[Melissa] Farrell reported that the [Ministry] does not intend to review the Courtyard report, nor to conduct a new compensation review.'…And then below that, she advises that it wasn't binding: '..and that the [Ministry] will not agree to a binding report. She referenced several inherent problems with the Courtyard report…' So those are the items that Melissa Farrell raised at that meeting about the Courtyard report; is that correct?

A. Yes, and that was actually the first time we really heard any explanation about why the Ministry had concerns about Courtyard and what the nature of those concerns were, so that was April of 2013.

---

726 Premier's Statement on Renewed Negotiations with the Ontario Medical Association, February 16, 2017 (Exhibit 279, Tab 29); Joint Statement by Premier Kathleen Wynne and Minister Eric Hoskins on the Province's New Ontario Medical Association Negotiating Team, February 21, 2017. Online: https://news.ontario.ca/opo/en/2017/02/joint-statement-by-premier-kathleen-wynne-and-minister-eric-hoskins-on-the-provinces-new-ontario-med.html; accessed March 28, 2017 (Exhibit 279, Tab 55).

727 Testimony of Laura Pinkney, Transcript, December 2, 2016, at pp. 112 - 113.

Q. Right. So at that point, the AOM wanted Courtyard and was asking for Courtyard to be implemented for the pay equity, as a pay equity measure.

A. Yes, or asking why it couldn't be, and if it couldn't be, what else might be used in its place.[728]

C. The MOHLTC has a history of not responding to allegations of gender inequity raised by the AOM.

1042. In a letter to former Minister George Smitherman in November 11, 2004, AOM President Elana Johnson wrote: "As an all women profession, the lack of parity also raises the issue of equity." She testified that: "We were increasingly coming to understand that we, as an all women profession, were being asked to wait over and over again and not being paid equitably with our predominantly male comparators."[729] No response was received to this correspondence which ultimately led to the AOM launching the campaign called the Storks Don't Deliver Babies Campaign.[730]

1043. The Ministry failed to act at any time when the AOM raised the issue of pay equity and systemic gender discrimination. AOM President Elizabeth Brandeis testified to this:

Q.… Did you speak to the Ministry about the fact that you thought this was gender discrimination?

A. Yes. So in many of the correspondences we had with the Ministry at that point, we did start to speak of this as a gender-based issue.

Q. And did the Ministry ever tell you that it wasn't?

A. Not specifically. They -- and again, I would have to go to the exact documents, but we were told things like there's compensation restraint and that's why we can't talk about this, but not any -- so it was a lot of deflection of the issue of equal pay and gendered pay and that we can't talk about that because we're under compensation restraint restrictions.

Q. And were you ever told by the Ministry that they'd done their own analysis and there wasn't any gender discrimination?

A. No.

---

728 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at pp. 166 – 167.

729 Package of Materials prepared by AOM for MPGs to meet with MPPs re: Background Information about Midwifery and Benefits to the Health System attaching multiple Fact Sheets, (November 11, 2004), AOM0005927. Elana Johnson, (Exhibit 85, Tab 57), in "Risks to Under-Compensating Midwifery", at p. 2.

730 Testimony of Elana Johnson, Transcript, October 5, 2016, at p. 42.

Q. Had they ever provided you with any analysis to show that it doesn't constitute gender discrimination?

A. No.[731]

1044. Ms. Brandeis summarized the MOHLTC's lack of analysis:

Q. "the Ministry responded but they didn't have an answer with respect to the pay gap when that issue was brought up. Did the Ministry ever come up with an answer to that issue as to addressing the pay gap?

A. No. Again, that's why we find ourselves here.

Q. And you were also asked questions about whether or not the issue of gender had been raised in respect to the AOM documents. Did the Ministry ever raise the issue of gender in your discussions with them and the issue of whether there was a potential for discrimination in the compensation and funding of midwives' work?

A. No. When these issues were being raised and articulated in our correspondence with the Ministry, we never received any correspondence back that committed in any way to providing a gender-based analysis to evaluating our work or our compensation.[732]

1045. Ms. Brandeis confirmed that since Mr. Durber's report that analyzed the compensation of midwives was provided to the Ministry, the MOHLTC has not provided the AOM with any other analysis of midwifery work since then.[733]

1046. Ms. Lisa Weston, former AOM President, wrote to Melissa Farrell on April 23rd, 2013:

Midwives are not willing to accept that the pay equity gap experienced as a female-dominated profession, providing care to women, has no remedy. It is untenable for the Ministry to not acknowledge or concretely plan to address the gender-based discrimination faced by midwives. The Human Rights Code states that every person has a right to contract on equal terms without discrimination because of sex, which includes the amount paid in a contract." [734]

1047. The AOM received no response on this specific paragraph of the letter.[735]

---

731 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at pp. 117 – 118.

732 Testimony of Elizabeth Brandeis, Transcript, October 11, 2016, at pp. 11 - 12.

733 Testimony of Elizabeth Brandeis, Transcript, October 11, 2016, at pp. 118 – 121.

734 Testimony of Kelly Stadelbauer, Transcript, October 14, 2016, at p. 34 -35.

735 Testimony of Kelly Stadelbauer, Transcript,, at p. 35.

D. The MOHLTC ignored internal warnings that there could be *Code* violations

1048. Ms. Pinkney testified that the Negotiations Branch had identified that there might be a Code violation at the time of the release of the Courtyard report:

Q. It says: 'while not mentioned by AOM, there is an outside risk they could bring an equity issue forward under the Human Rights Code, but [nurse practitioners] are a female-dominated group as well, and the argument to compare Midwives scope of practice to Obstetricians is not clear.' And whose analysis was that?

A. This was done by the Negotiations Branch at the time that they were leading the negotiations.

Q. And this was because the AOM had mentioned gender equity in passing?...

A. Yes. And you'll see some other documents in the affidavit that the Ministry's understanding at the time in terms of equity, the AOM had been comparing equity amongst providers, so looking at other professions, that being physicians, nurse practitioners, or midwives in other provinces.

Q. But they had referred to gender equity.

A. Yes, there's a reference to it here.

Q. … And just so that I can understand this, you're saying that this analysis about whether or not there might be a complaint under the Code was an analysis done by the Negotiations Branch as opposed to your branch?

A. Negotiations Branch were the ones that had, yes, had brought that forward as part of this deck. This is a Negotiations Branch deck. [736]

1049. Ms. Pinkney also testified to another email in which gender equity was raised by the AOM; Ms. Seetha Raja attempted to prompt her colleagues to recognize that the AOM is expecting equity with other professionals with whom should be benchmarked against:

Q. But you'll recall that they [the AOM] actually referred to gender equity.

A. My understanding is what Seetha is referring to -- referring to here is what we had understood historically from the AOM was pay equity was referring to equity with other professionals. I will --the issue of pay equity did come up as part of the negotiations when there were questions around if this was a pay equity payment, then it would be exempt from the compensation restraint. But

---

[736] Testimony of Laura Pinkney, Transcript, November 4, 2016, at pp. 58 – 60.

historically what the program area understood in terms of equity, was equity with other comparator professions, namely, physicians and nurses or nurse practitioners.

Q. But you'll recall that at this point … the document which referred to the fact that they had mentioned gender equity right at this time.

A. Yes. And I'm not certain if this is Alex [Lambert] following up on that trail where Seetha is clarifying her understanding or not."[737]

E. MOHLTC failed to act on comparisons made by the AOM to other male predominant government workers

1050. The AOM also raised to the MOHLTC the differences in treatment between the female dominated midwives and male dominated groups that negotiated with the Ontario government.[738] Handwritten notes from a February 26, 2011 negotiations meeting shows that the AOM was raising issues of pay inequity, historic underfunding of midwifery compensation, and directly relating it to the generous settlement provided contemporaneously by the government to the male dominated OPP:

"pay equity - appropriate place based on competencies, etc. Historic and systemic. Years of no negotiations" and "constantly being pushed off. Midwives subsidizing the system. Chronically underfunded. Profession was documented... One-time equity adjustment to address…chronic pay inequity. Not looking at just making" -- okay -- "OPP exception - trying to square it with 0% policy. Not looking at just making it up 4%. It's about the historic underfunding. Core problem, not just about recession. Willing to look at 0% and 0%, but not in absence of looking at historic underfunding." And MGS says "pay equity legislation…"remains current…. AOM: What are the goals of pay equity legislation? A pay equity issue. How would midwives be different than OPP? … MGS [Ministry of Government Services]: Not different with…respect to the solution. OPP is compliant with the legislation. OPP tied to highest paid police service in province. …Tie into an overall policy objective. Not just OPP arbitrators…[739] [740]

1051. When asked whether the MOHLTC investigated this claim of a systemic problem of underfunding and contrasted this with a male dominated profession with whom the MOHLTC negotiates, Ms. Pinkney responded: "Well, in terms of what we

---

737 Testimony of Laura Pinkney, Transcript, November 8, 2016, at pp.152 – 153.

738 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 29.

739 "PHCB Notes from AOM Meeting, dated February 1, 2011", Affidavit of Laura Pinkney – September 6, 2016 (Exhibit 158, Tab 127).

740 Testimony of Laura Pinkney, Transcript, November 8, 2016, at pp. 156 – 157.

looked at, it would have been historic funding for the program, but if you're asking if we did a specific report, no."[741]

1052. Rather than investigate the possibility of systemic gender discrimination, this concern was ignored and dismissed by the MOHLTC:

Q. This an e-mail between -- from yourself to Ms. Raja and the AOM had flagged the issue of the OPP where the MGS had negotiated a 5 percent retro increase and a catch-up clause at the end of the current contract. And if I recall correctly, it was a catch-up to being paid whatever the highest paid police in the province were paid in the out year?

A. I'm not sure if this is referencing when they say they did flag, I don't actually think that was the AOM. I'm assuming Health Sector Labour Management Policy Branch may be the "they" because this may be raised during our discussions, so I am thinking --

Q. Oh, I see, because I think the AOM also did raise it. You are saying you think this was the Negotiations Branch saying... somebody may raise it.

A. In the context of this e-mail it would read that way. But I would agree with you it was raised as part of negotiations."[742]

F. Canada Wide Midwifery Comparisons Embed Gender Bias

1. Introduction

1053. Following the completion of the Courtyard Report, the MOHLTC made a large issue of the lack of an appropriate cross-jurisdictional review to determine midwifery compensation; Ms. Farrell described it as "the most pressing issue"[743]. It is striking that none of the MOHLTC experts discussed the need for cross-jurisdictional comparisons in their expert reports.

1054. Ms. Farrell also described how jurisdictional review is a policy within the MOHLTC:

When it comes to compensation though, our policies associated with how we set and define compensation have largely been around the issues that we have talked about before which is where we have recruitment and retention issues, evaluating what we've seen in terms of compensation across jurisdictions, where there has been compensation increases to see whether or not we're being fair in terms of those compensation increases from one provider group to another or

741 Testimony of Laura Pinkney, Transcript, November 8, 2016, at p.158.

742 Testimony of Laura Pinkney, Transcript, November 8, 2016, at p. 154.

743 Testimony of Melissa Farrell, Transcript, December 2, 2016, pp.172 – 173.

some assessment of what we're seeing in terms of the increases that have been provided in that way.[744]

1055. Such a policy embeds systemic gender discrimination that may exist in other jurisdictions, into the compensation of women in Ontario. For example, Alberta lacks pay equity legislation and, therefore, comparisons to the compensation of women in Alberta should be highly suspect as to whether their compensation is free of gender discrimination.

1056. Dr. Pat Armstrong testified to the inappropriateness of using midwives in other jurisdictions at the comparator:

if you're using midwives in other provinces, there is no guarantee that their compensation is free of gender bias. So, to simply base it on that would be to also fail to provide gender analysis."[745]

2. Jurisdictional Review Not Key Focus of Courtyard Process

1057. The process of a joint compensation review was negotiated between the AOM and the MOHLTC in the winter of 2009. The actual review was an eleventh hour concession made by the Ministry, however, they would not agree to remove a cross-jurisdictional review element to the compensation review process. This was despite the protests by the AOM that this would contribute to inequity if inequitable pay for midwives existed in those other jurisdictions. None of the MOHLTC's witnesses during these proceedings were present at these negotiation meetings. AOM Executive Director Kelly Stadelbauer was present during these negotiations where the compensation review parameters were discussed:

This was a real point of contention right from when we developed the MOU in 2009. And the Ministry representatives were quite insistent on including a jurisdictional review and we were quite insistent that that was not appropriate. And our rationale at that time was that, if we're talking about equity in terms of pay, then to look across other jurisdictions at other female-dominated professions, female-dominated midwifery groups in this case, that that's inappropriate because those female-dominated midwifery groups can be subject to the same kind of gender bias that we're trying to look at here.

So, we fought that quite strongly originally in developing the MOU of 2009. We eventually conceded the point because we felt that we could address it with the consultant once they were hired. So, it is sitting in the MOU."[746]

---

744 Testimony of Melissa Farrell, Transcript, December 2, 2016, pp.31- 32.

745 Testimony of Pat Armstrong, Transcript, March 20, 2017 p. 37.

746 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, p. 41 – 42.

1058. Ms. Kilroy had a similar recall of the events:

> *And that was the reason why we expressed concerns initially about jurisdictional comparisons being included in the Courtyard report because, you know, midwifery is a female-dominated profession across the country, and we really wanted to know if our pay was equitable on the basis of our sex….We argued against its inclusion at the table. ….We were, like, no, we don't think that should be included because it's really about the province of Ontario and, of course, comparing to other … groups of the same profession who may experience the same discrimination or disadvantages in their pay is problematic…we talked about it at the table and the government was like, absolutely not, we want to look at other jurisdictions and we agreed to that in the end."*[747]

1059. The Request for Services documents were sent by the MOHTLC to the AOM to review in early 2010 in preparation for the compensation review. Ms. Stadelbauer was questioned by the MOHLTC's counsel about this process:

> *we wouldn't have felt that at that point we could go and change what was in the MOU….when we were discussing the MOU before it was finalized, we raised the issue of the jurisdictional analysis and the inappropriateness of that, and then decided that that was a fight that we could continue with the consultant. We could bring those issues to the consultant and have them decide. It didn't feel like when the RFS was being developed that that was an appropriate place, for example, to re-raise the issue of jurisdictional analysis.*
>
> *Q. You haven't attached any documents at all to your affidavit that show that you had any concern about a jurisdictional analysis at the time of negotiating the MOU.*
>
> *A. I can tell you it was a significant point. And I can tell you I was the one that went to the Pay Equity Commission's Web site to learn that that was, in fact, inappropriate when you're looking at a female-dominated profession.*[748]

1060. John Ronson, of the Courtyard Group, testified to the issue of jurisdictional review raised during the joint compensation review. He understood the MOHLTC's Request For Services stipulated a jurisdictional review as one of "three things that the vendor should consider, not required to limit the vendor to those three things, but they should consider these three things."[749]

1061. The first meetings of the joint compensation review committee met. Ms. Stadelbauer explained the decisions that were made by the Steering Committee. Again, none of the MOHLTC's witnesses during these proceedings were present

---

747 Testimony of Katrina Kilroy, Transcript, October 6, 2016, pp. 27 – 28.

748 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016 pp. 133-134.

749 Testimony of John Ronson, Transcript, October 14, 2016, p. 95.

at these negotiation meetings; whereas, both Ms. Kilroy and Ms. Stadelbauer were actively involved in the compensation review committee meetings:

When we got to this first meeting of the steering committee on July 28th, 2010, the issue was again raised because it was in the MOU and in the Statement of Work that Courtyard was required to undertake. And, again, we brought forward that same argument, that it was inappropriate, and that the Pay Equity Commission on their Web site at that time essentially said a similar kind of a thing, that the jurisdictional review is not appropriate because it can just reinforce the same bias and reinforce the market inequities for those female-dominated groups. Courtyard effectively agreed with that argument and the table [the steering committee] agreed with that argument….Well, we had -- we decided that, as a group, we decided that the jurisdictional review should still continue with a focus just on British Columbia and Alberta because their model of how they were set up as independent contractors was similar to Ontario, but that the report would downplay it. The report wouldn't give the same emphasis to that as it would to comparator professions in Ontario.[750]

…..

"I think where that's best reflected in the report is in the evaluation questions which are on page 3 of the report. And the evaluation questions is where, in our discussions as a steering committee early on in the process, the original evaluation questions at Courtyard brought to us based on their understanding of the Statement of Work included a jurisdictional analysis and these evaluation questions don't."[751]

1062. The Courtyard report was completed in the first week of October 2010, following extensive opportunity to both parties to provide feedback into the report. The Courtyard report is consistent with the testimony of the AOM witnesses, Ms. Kilroy and Ms. Stadelbauer, that there was discussion about the AOM's position on cross-jurisdictional comparisons and there was consensus that there was going to be a focus on Alberta and British Columbia.

3. MOHTLC Decided Other Midwives Were Comparator instead of CHC Physicians After Courtyard Recommendation of 20% Based on CHC Comparator

1063. It appears that it was Minister Matthews who insisted on a jurisdictional review; however, there seems to be a lack of briefing to the Minister that reliance on such a review may introduce gender inequities embedded in other jurisdictions into the compensation of Ontario midwives:

---

750 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, pp. 42 – 43.

751 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, p. 145.

Q. And at tab 241, again there's the handwritten notes about a call with the Minister's office re: the negotiations, and it says…"Minister thinks reference point should be other jurisdictions, not necessarily other professions. "Minister not comfortable [with] 10%." So these are then your instructions to proceed with the comparison to the other jurisdictions and to not proceed with 10 percent, right?

A. We'd already been looking at other jurisdictions and comparators, but certainly, the notes here do indicate some comments with regards to jurisdictional scans as opposed to other professions… we did analysis with regards to what increases would mean and what jurisdictional scan, how the comparators were, and what increases would look like compared to other jurisdictions, and I recall there are charts in some of the earlier documents we've looked at that…do lay out the jurisdictional scan.[752]

1064. The MOHLTC issued Request for Services (RFS) required the successful vendor to identify methodologies it proposed it would use up front; after the release of the Courtyard report, the MOHLTC took issue with these methodologies.[753] The RFS required communications with the MOHLTC during the project, which Courtyard fulfilled through weekly written project summaries. The RFS shows that the MOHLTC intentionally focused on issues with the jurisdictional review, only once they saw the results of the Courtyard report, as a means to avoid confronting the wage gap that had been exposed.

4. MOHLTC did not act on the AOM's concerns for potential gender discrimination in Use of Midwives Across Canada as Comparator

1065. Ms. Farrell testified that:

(a) She was unaware of whether or not there has been any analysis in those other jurisdictions to determine whether their pay, the pay of their midwives is free of sex discrimination;[754]

(b) the AOM made the point that they were concerned about the jurisdictional analysis because it would not help to determine whether there is sex discrimination in the compensation of midwives in Ontario to compare them to other midwives;[755]

---

752 Testimony of Laura Pinkney, Transcript, December 2, 2016, pp. 83-84.

753 "Request for Proposals for General Management Consulting Services for Compensation Review Committee, dated June 8, 2010" Affidavit of Laura Pinkney (Exhibit 158, Tab 79) at p. 16.

754 Testimony of Melissa Farrell, Transcript, December 7, 2016, p. 40.

755 Testimony of Melissa Farrell, Transcript, December 7, 2016, p. 41.

(c) The AOM said that under the Pay Equity Act one cannot point to a lower paid comparator in another province; that it is necessary to stay within one`s own jurisdiction;[756]

1066. Ms. Stadelbauer explicitly raised with Ms. Farrell in April 2013 that when the government moved to having this jurisdictional focus, in fact, then that became a barrier to actually sorting out whether there was -- their compensation was free of discrimination because the MOHLTC was importing the pay of other female dominated professions in other provinces.[757]

1067. Ms. Farrell was very clear about the MOHLTC's approach to midwifery compensation and the intent to only look within the midwifery profession itself rather than with other professional comparators, thereby, potentially reinforcing gender discrimination that may exist in those other jurisdictions:

A. Our opinion has been, and certainly was in the conversations that I was involved in anyway, was that we thought it was really important, given the fact that midwifery is now an established program, to look at midwifery across jurisdictions and look at other jurisdictions in Canada and otherwise.

Q. Okay. But we have agreed that that wouldn't address any issue about systemic sex discrimination to do it that way?

A. Right. "[758]

5. No Search For Lower Paid Jurisdiction for CHC Physician Compensation Comparison

1068. There was no evidence presented that prior to 2012 the MOHLTC used a similar cross-jurisdictional review process with physicians. Ms. Stadelbauer noted:

Q. And can you compare what the Ministry did with the OMA when it aligned the compensation of the CHC physicians to other primary care providers in Ontario with what it was suggesting here?

A. Yeah. But my understanding is that the Ministry didn't look outside of the province when it was aligning the CHC physician compensation, that it only looked inside of the province, and that those were the comparators were other family physicians inside of Ontario. So, it was a different process."[759]

---

[756] Testimony of Melissa Farrell, Transcript, December 7, 2016, p. 41.

[757] Testimony of Melissa Farrell, Transcript, December 7, 2016, p. 41.

[758] Testimony of Melissa Farrell, Transcript, December 7, 2016, pp. 53-54.

[759] Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, pp. 41-43.

6. MOHLTC's Internal Jurisdictional Review Problematic

1069. The MOHLTC did proceed to do its own internal jurisdictional review after the Courtyard report was released, in an apparent attempt to justify its lack of addressing the wage gap identified by Courtyard.

1070. The process used by the MOHLTC was extremely basic and flawed. They used the same two jurisdictions as Courtyard did, despite their criticism that Courtyard only used two. They *"simply relied on the amount of detail and information that they [the contacts in the BC and Alberta governments] provided to us."* And they received an average annual compensation from the BC government but failed to compare it to the average annual compensation of an Ontario midwife, making the compensation in the two jurisdictions look comparable" [760]

1071. The MOHLTC relied on their findings to justify the dismissal of the Courtyard findings:

> *Q. Did the Ministry, again to your knowledge and your information, did the Ministry think that there was a compensation gap as identified in the Courtyard report or elsewhere?*
>
> *A. No.*
>
> *Q. Why do you say that?*
>
> *A. I say no, because of the way in which the Courtyard -- I guess what I would say is it didn't appear to show us that there was a compensation differential based on what we were seeing with other jurisdictions, given the fact that these other components of compensation hadn't been included."*[761]

1072. It is apparent from the MOHLTC's counsel's questioning in these proceedings that the MOHLTC still believes that such a comparison to determine equitable pay is appropriate.[762]

7. The inequitable application of the Restraint Laws to midwives

1073. In 2010, and prior to the start of the Courtyard compensation review, the MOHLTC introduced the Public Sector Compensation Restraint Act. At no time before or during the compensation review project did the MOHLTC advise the AOM that the findings of Courtyard would be subject to this new legislation. It

---

760 Testimony of Fredrika Scarth, Transcript, December 9, 2016, pp. 153-154.

761 Testimony of Melissa Farrell, Transcript, December 2, 2016, pp. 180-181.

762 Testimony of Kelly Stadelbauer, Transcript, October 11 2016, pp. 136 – 149.

was only after Courtyard released its findings that the MOHLTC used the Compensation Restraint legislation as an excuse to not provide the equity adjustment advised by Courtyard.

1074. The AOM raised with the MOHLTC that, legally, the legislation did not apply to the midwives because they were independent contractors; and that the legislation recognized that equity issues were exempt from the legislation. The MOHLTC response was that the legislation may legally not apply to midwives, but it did in spirit. The MOHLTC went on to say that the Pay Equity Act did not apply to midwives and but would not apply the spirit of the legislation that exempted payments that were intended to provide equity. Both AOM and MOHLTC witnesses testified to this ongoing contentious issue.

1075. Ms. Stadelbauer testified that the MOHLTC and AOM had had "a fairly spirited conversation" about the fact that this piece of legislation was intended to restrain the compensation of public sector workers but that it was recognized within that legislation that it was inappropriate for compensation to be restrained for pay issues that might fall under the Pay Equity Act or the Human Rights Code:

we were bringing forward the point that the issue we had put in front of the government that was illustrated in the Courtyard report fit within the spirit of that legislation, and we were arguing that, therefore, the government should make an exemption for midwives in their compensation restraint legislation, first of all, because they are actually not covered by that legislation because midwives are not employees; but, second, because the issues that we're bringing forward are essentially pay equity issues.[763]

1076. The AOM had told the MOHLTC that they would comply with the spirit of legislation, once their pay had been adjusted for equity.

…we weren't seeking a compensation raise, but rather, an equity adjustment, and that's how we were arguing that the wage restraint policy should not apply to such an adjustment, and that with appropriate adjusted pay, we would then be very willing to comply with the wage restraint of zeros to bring us in line with our comparators, and then comply with that wage restraint policy.[764]

1077. In the Compensation Restraint legislation, an exemption existed for adjustments that were required under the Pay Equity Act and the Human Rights Code. Ms. Farrell agreed in her testimony that this was likely an effort within the legislation to try to separate and not have affected by compensation restraints matters that were required in terms of equity adjustments. [765]

---

763 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, at p. 170.

764 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at p.161.

765 Testimony of Melissa Farrell, Transcript, December 2, 2016, at pp. 211 – 212.

1078. However, there was no assessment by the MOHLTC to ensure that midwives were indeed subject to that exemption and that such an equity adjustment as the Courtyard report recommending should be exempted under that legislation. No analysis was made of whether this would be an appropriate Human Rights Code adjustment required for midwives working as independent contractors to ensure that there was no systemic sex discrimination in their compensation and, therefore, exempt from restraint.

1079. Ms. Pinkney testified that a policy statement was later developed to cover those who were outside of the legislation. The MOHLTC recognized that the legislation did not apply to midwives; however this policy statement, she said, did apply because "That is what the briefing note says at the bullet that says: "The Association of Ontario Midwives bargains on behalf of the registered midwives in the province and, as such, the policy applies to midwives." That's what it says here."[766]

1080. In summary:

(a) MOHLTC witnesses testified that the AOM had raised the issue that equity payments were exempted from the legislation.[767]

(b) The MOHLTC would not apply the exemption because the PEA did not apply to midwives. [768] [769] [770] [771]

(c) The MOHTLC understood the AOM's position to be that the "the compensation review undertaken by Courtyard and the subsequent recommendation outlined in the report reflected, in their view, a pay equity issue and so that had been the position that had been brought forward" whereas the MOH saw the report as a non-binding compensation review.[772]

1081. The MOHLTC acknowledged internally, at the time, that they needed to deal with this matter.[773]

---

[766] Testimony of Laura Pinkney, Transcript, November 8, 2016, at pp. 154 - 155.

[767] Testimony of Laura Pinkney, Transcript, November 4, 2016, at pp. 29 – 30; Testimony of Melissa Farrell, Transcript, December 2, 2016, at p. 211.

[768] Testimony of Laura Pinkney, Transcript, November 4, 2016, at pp. 29 – 30.

[769] Testimony of Laura Pinkney, Transcript, December 2, 2016, at pp. 37 – 38.

[770] Testimony of Melissa Farrell, Transcript, December 7, 2016, at pp. 219-220.

[771] Testimony of Pinkney, Transcript, December 2 2016, pp. 99-102

[772] Testimony of Pinkney, Transcript, November 4, 2016, at pp. 30 – 31.

[773] Testimony of Pinkney, Transcript, December 2, 2016, at p. 103.

1082. The MOHLTC witnesses testified that they had not considered that the midwives request for an exemption for pay equity might fall under the exemption for the *Human Rights Code*.[774]

1083. The MOHLTC witnesses testified that there was no policy in place that would have led the MOHLTC to undertake any kind of analysis about whether the midwives had any Human Rights Code entitlement. The MOHLTC had not done such an analysis because the midwives had only raised the issue of an exemption in reference to the *PEA*[775], thereby putting the onus on midwives to ensure their human rights were upheld.

1084. The compensation legislation was used to justify the lack of examination of the compensation of midwives and the lack of any equity adjustments to compensation.[776] [777]

1085. An email of May 26, 2011 showed that the MOHLTC acknowledged the "relativity issue", and had planned a "special review to follow up":

> *The government agrees that there is a relativity issue but does [have] some concerns with the comparators or the range of the differential. Instead, the Minister will be requesting that a special review be undertaken and the results be presented directly to the Minister upon completion.* [778]

1086. However, no review was undertaken: "We did do further review of the report, if that's what that's referring to, but I can't specifically recall what that ties into, really".[779] The AOM continued to raise the pay equity issues, but the MOHLTC was unwavering in its resolve to not look at the possibility of an exemption under the legislation.

> *Q. What steps did you take in response to the AOM's concerns that you learned of at that time?*
>
> *A. I certainly took this back, though, and talked to the Health Human Resource Division within the Ministry, had conversations with the team… Spoke to my ADM at the time, Susan Fitzpatrick, about the advisory committee in particular, and whether or not we could reconstitute a new advisory committee where we could talk about programs and services. What became really clear through the discussions that I was having with the team and internal within the Ministry was*

---

774 Testimony of Pinkney, Transcript, December 2, 2016, at pp. 37 – 38.

775 Testimony of Pinkney, Transcript, December 2, 2016, at pp. 35 – 38.

776 Testimony of Pinkney, Transcript, December 2, 2016, at p. 174.

777 Testimony of Melissa Farrell, Transcript, December 2, 2016, at p. 174.

778 "Handwritten notes from unknown MOH staff re negotiations meeting with AOM", Government Documents - Laura Pinkney: Volume IV (Exhibit 160, Tab 263).

779 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 103.

that there are -- the compensation restraint policy applied, but the compensation restraint policy doesn't apply to everything. Certain program improvements fall outside of compensation restraint. So I felt that I could go back to the Association although I wouldn't be able to talk to them about any compensation increases. That was quite clearly the response that I received when I was talking to others about this.[780]

1087. Ms. Farrell also testified to some of these discussions:

I did ask the question of, well, could we just do another report at the time, so why don't we just do some other assessment, or why don't we just do another report? The Association was particularly interested, though, in a binding report, and given the salary, given the constraint and salary constraint at the time, there was no -- there would be no interest and no opportunity or ability for us to agree to a binding assessment.[781]

1088. The MOHLTC had planned to continue the compensation restraint policy until the budget is balanced which was planned to occur in 2018; that is, there was no plan to address the allegations raised by the midwives until at least eight years after the release of the Courtyard report:

This is part of what we were trying to get clarification on too as the program managers for the midwifery program was what could be we, in fact, this is part of I had said on Friday as well, what new to this portfolio part of what I was investigating and trying to determine was what exactly does all this mean and what exactly can we do, understanding that there is compensation restraints currently in place, what could we do? What can we do with the Association and with midwives?"[782]

1089. Ms. Naylor and Ms. Farrell gave conflicting testimony as to whether the midwives' issue of equitable pay was about to be addressed by the MOHLTC, outside of the Tribunal proceedings. Ms. Naylor said:

Q…Are you saying there are now no compensation restraints with respect to the midwifery program?

A. Right now the existing transfer payment agreement Funding Agreement holds. So, it sets a level of compensation that has been in place for a number of years but there is a process underway now to replace that with a new Funding Agreement that would recognize the need for compensation increases for midwives.

---

780 Testimony of Melissa Farrell, Transcript, December 2, 2016, at pp. 169 - 172.

781 Testimony of Melissa Farrell, Transcript, December 2, 2016, at p. 173.

782 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p. 122.

Q. So, in other words, the new Funding Agreement would not be subject to compensation restraints?

A. Correct.[783]

1090. Whereas, Ms. Farrell said:

A. We're setting the compensation, but it's still in the context of where we stand, even still today, largely still stand today in terms of compensation restraint. Now, again, it's been lifted for some targeted groups, and I think we're starting to see that change.

Q. And are midwives one of the targeted groups it's been lifted for?

A. That part I'm -- I don't believe so, not yet anyway. That's my understanding.[784]

G. The Premier's letter

1091. The AOM received a letter from Premier McGuinty on September 24 2011 in which he said:

Ontario Liberals have significantly expanded the scope of practice for midwives so they can provide more services to patients. We believe that midwives should be able to work in accordance with the full scope of their practice in all environments, including hospitals. We also believe that midwives should be fairly compensated for the important work they do. We support recognizing midwives and their compensation relative to other health care professionals."[785]

The AOM leadership took this as a positive response to their pay equity concerns, as former AOM President Katrina Kilroy testified:

Q. So when you read that, you thought that "fairly compensated" meant wage parity or pay equity? What did you think?

A. Well, I thought it meant "fair", which I would include in the definition of fair, that it's equitable.

Q. And when he said, "We support recognizing midwives and their compensation relative to other health care professionals," when you read that, who did you think he meant by "other health care professionals"? […]

---

783 Testimony of Nancy Naylor, Transcript, November 3, 2016, at p. 183.

784 Testimony of Melissa Farrell, Transcript, December 2, 2016, at p. 261.

785 "Letter from Premier D. McGuinty to K. Kilroy (AOM President) and J. Berinstein (AOM Director of Policy and Communications) re: support for midwives and their fair compensation (September 2, 2011)", Katrina Kilroy Footnotes to Affidavit (Exhibit 91, Tab 78).

A. We thought -- we were very encouraged by that statement. We had been placing an argument in front of the government for quite some time that our compensation was unfair in relation to the comparators that the government had chosen, nurse practitioners and CHC physicians. So I think it's perfectly reasonable to think when the government responds, they are referring to those, and uses the words "relative to other health care professionals," that they are implying the same comparators…Or similar, or at least that they're going to do some kind of comparative exercise.[786]

1092. The AOM leadership was expecting that this was the beginning of a commitment to action on the midwives' allegations of a lack of gender equity in their compensation. Ms. Kilroy testified:

we're hearing the Premier commit to that, and to those principles of fair compensation relative to other health care professionals, and we were -- we were quite excited to get this letter actually…. we made the assumption that, as the Premier of the province writing a letter like this that specifically talks about midwifery compensation, he would have been well-briefed on what the Association had been pursuing and putting forward.[787]

There was no action by the MOHLTC following this letter.

H. Threat of legal action prompts some internal MOHLTC Analysis of AOM Allegations

1093. By April 2013, it became clear to the AOM that the MOHLTC had no intention of ever undertaking a process to address the midwives' concern of systemic gender discrimination. Ms. Farrell's testimony supports this conclusion:

Susan's comments are below. 'I do not want to provide feedback on the report. I think we should say we are not interested in further discussion on it. We have no comment'." […]

A. Yes. So, this is the exchange that occurred before the meeting that took place with the midwifery association. Susan is saying at this time that this is a non-binding report. We have all kinds of issues with it. We have identified those issues before. They have been asking for a blacklined version of the Courtyard report. So, essentially what they were asking us for, that became very clear throughout this particular time, is they wanted us to take the report and blackline the version of it to identify all of our concerns with it which she wasn't interested in doing.

In the end, although there was this exchange back and forth where she was saying this or this direction was given, in the end, I did specifically say these

---

786 Testimony of Katrina Kilroy, Transcript, October 7, 2016, at pp. 54 – 55.

787 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, at p. 194.

bullets that are included in here to the Association and they were provided to the Association at some point in time in writing too to reflect our concerns associated with the report.

Q. Right. But you can appreciate from their point of view that they thought they had the commitment of the Minister back in December to have a discussion about the report?...And in the end, as a result of this, very little discussion about the report took place because, if you were thinking that the Courtyard report was a summary thing, those two paragraphs that I just read out to you as the response are very summary as to what your concerns are….And that was because really the government wanted to shut down further discussion about the report?

A. Because of our concerns associated with the report, the concerns associated with the report we had indicated to the Association on multiple occasions, they were looking for it in writing.

Q. I thought it was supposed to also happen as a discussion at this meeting?

A. And it was a discussion at the meeting. We talked about our specific concerns with it being the two comments in the two specifics statements that we just read… And that is where they explicitly said they were really looking for a blacklined version of the Courtyard report back from us. We weren't going to do a blacklined version of the Courtyard report because of the issues that we had identified associated with it.[788]

1094. Ms. Farrell reported on this meeting to ADM Fitzpatrick's office and the Minister's Office.

"It was a tense conversation. They [the AOM] were expecting us to:

-develop an MOU committing funding for programs (even though we plan to fund them through regular business planning processes, they want to know in advance what we are willing to fund);

-recognize that there's a pay equity issue, as described in the courtyard report, related to midwifery compensations. We did not acknowledge this point and agreed to follow up;

-commit to a process including timelines for how the pay equity issue will be resolved (recall, the courtyard report recommends a one-time 20 percent increase to their compensation);

-they are willing to accept zero increases for the next two or three years (if consistent with other providers) and as long as the pay equity issue is addressed

[788] Testimony of Melissa Farrell, Transcript, December 7, 2016, at pp. 211 – 213.

They specifically asked if we plan to address the courtyard report, commission an updated report and provide timelines for increasing their compensation. We said no to all three. They have given us a deadline to officially respond of April 29th. If we cannot make commitments to address their perceived pay equity issues and define a process they will take action."[789]

1095. Ms. Weston sent a letter to Ms. Farrell on April 23, 2013. This letter prompted a string of emails, none of which suggested an investigation into whether or not the midwives were experiencing systemic gender discrimination, including the staff at the Labour Relations Secretariat at the Ministry of Government Services. Only Ms. Farrell raised the possibility that the midwives' concern could potentially be exempt from compensation restraint because wage parity included issues of discrimination:

so, the April 24th one at 6:24 p.m., which is at the bottom of page 3, you say: 'I'm not sure I understand the response...', this is from the Labour Relations Secretariat, '...as I thought wage parity addressed issues of discrimination and fell outside the compensation restraint directive.'"[790]

1096. Ms. Farrell testified to the steps she took once the April 23rd letter was received:

Q. And what steps did you take in response to these letters, the letter to the Premier and the letter to the Minister which is at Exhibit 53?

A. So this -- we again followed up with our -- you know, sought legal counsel, spoke to the Labour Relations Secretariat, discussed this with the Health Human Resource area within the Ministry, Minister's Office, Assistant Deputy Minister to determine if there's something, something else to infer from what we were seeing, and it appeared to be the same argument that we had been hearing for the last year.

Q. Did anything change from your perspective?

A. No.

Q. Why not?

A. Because it was -- it really was the same argument they were talking about. It's even referencing here the Courtyard report and the increases identified within that Courtyard report. They were talking about it in the context of gender discrimination and were talking about CHC physicians who are predominantly women and nurse practitioners who are predominantly women. I didn't see the connection.

---

789 "RE: AOM discussion", Government Documents - Melissa Farrell- Volume I (Exhibit 182, Tab 64).

790 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p. 223.

Q. And the Ministry then received the AOM's application to the Human Rights Tribunal in November 2013...Did that application contain new facts or new allegations that hadn't been raised with you before?

A. Yes. So it included a pay equity analysis that we hadn't seen before. It included a new argument that midwives should be compensated at 91 percent of the maximum CHC physician level, and also stated that we should be doing, every three years, be doing some sort of job evaluation or assessment for midwives.

Q. And when you received that application, what steps did you take?

A. So we took the application, met with legal counsel, went through it, obviously, line by line to assess the claim that was being made there, that was being made in it. Again, discussed with Labour Relations Secretariat and others, Minister's Office, went through all the steps within the Ministry to ensure that we were consulting and getting the advice from the appropriate groups."[791]

I. MOHLTC staff were unaware of legislation that protected women from gender discrimination and their obligations

1097. Ms. Pinkney testified that she was unfamiliar with how the PEA addresses systemic gender discrimination in compensation, unfamiliar with the term "systemic gender discrimination" and demonstrated that she was unaware of her obligations under the Code:

A. I'm not familiar with the details of the Act. In terms of when the issue was raised, as part of negotiations, we did undertake to take that issue forward and seek direction with regards to that specific complaint, so we sought out the advice of our internal experts in terms of addressing that question.

Q. Just to be clear, you still weren't aware of what systemic gender discrimination in compensation was?

A. No, I'm not familiar with that, that term.

Q. ..And did you ever have any understanding that the midwives, as independent contractors, would have any claim under the Human Rights Code with respect to making a complaint about the lack of their compensation, or rather, that their compensation was affected by their sex or gender?

A. There is in my affidavit a slide that references early on in the negotiations."

---

791 Testimony of Melissa Farrell, Transcript, December 2, 2016, pp. 182 - 184.

1098. At this point Ms. Pinkney referenced an internal MOHLTC Negotiations Branch slide deck of November 8, 2010 that suggested there was a risk that midwives `could bring an equity issue forward under the *Human Rights Code*.[792]

1099. Ms. Naylor confused the HRTO settlement process with the proactive requirement to investigate when an allegation is made; the settlement process occurred after the application was filed whereas the investigative process must occur when the allegation of the discrimination is made.

1100. Ms. Scarth testified that she was unaware of processes required under the Code:

> *Q.… what did you understand would be the processes for determining whether compensation is free of sex discrimination for those who are covered under the Human Rights Code and not under the Pay Equity Act, did you have any understanding of that?*
>
> *A. I would not say that at the time that I took on this role I had a specific understanding of, you know, what specific processes would be followed for assessing that within the context of the Human Rights Code.[793]*

1101. Ms. Farrell also testified that other MOHLTC staff who weighed in on the issue of midwifery compensation were not well informed about the issues: one staff member from the Labour Relations Secretariat thought midwives were asking for compensation equal to obstetricians; and one director at the Health Human Resources Division thought that midwifery salary levels were "equivalent or better than NPs. Not sure what the issue is here in terms of compensation [sic] rates." [794] From this communications it appears that MOHLTC staff, including director level staff, were also uninformed about obligations that they had under the Code.

J. No MOHLTC Policies or Processes to Ensure Equitable Treatment and Freedom from Systemic Gender Discrimination in Compensation

1102. The MOHLTC initially used the Morton Report as a "measuring stick" to determine the comparable and equitable pay of midwives. This type of measurement is needed to continue to ensure their pay was equitable as a vulnerable female profession; Hay and Courtyard reaffirmed that the measuring stick was appropriate.

1103. However, the MOHLTC following the Courtyard report, refused to agree to use their method of measuring midwifery compensation, and therefore, there was no

---

792 Testimony of Laura Pinkney, Transcript, November 4, 2016, at p. 57.

793 Testimony of Fredrika Scarth, Transcript, December 8, 2016, at p. 140.

794 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p. 224.

tool to ensure midwifery pay was equitable. Ms. Farrell was asked during her testimony:

"Q. And if they don't use that as the tool, what do you think is the tool that would be used to determine and ensure that their pay is free of sex discrimination? If it isn't that tool, what tool is it?

A. I think that we would -- I think that -- I would have to think about what that tool -- what a specific tool would look like. Certainly in the way in which this was positioned and framed and the conversations that we had, it was not -- and certainly in terms of the Courtyard report, it wasn't put to us as a pay equity adjustment or about gender discrimination until the period that I mentioned on Friday where that became very clear that that is what they were arguing for.

Q. So, let's even assume now you're clear that that's what they are arguing for, what have you done since then now that you're clear?...To have a tool to be sure.

A. … there hasn't been a specific obligation of the government to look at a specific tool necessarily….

Q. Okay. And I guess this goes back to the other issue of what obligation you think the government has that they are setting the pay because the government is very clear that it's the one that's in charge of setting the pay, right?

A. Yes.[795]

1104. Ms. Farrell correctly identified that the MOHLTC did not have any tool for ensuring equitable compensation, seven years after the MOHLTC's rejection of the Courtyard report. Ms. Farrell also admitted that there was no process to ensure that the MOHLTC had an equitable process with the midwives that took into account what the government was doing in other negotiations and its impact on midwives compensation, particularly with other male dominated groups such as the OPP, corrections worker and the physicians. Ms. Farrell testified that the extent of such a process is that the MOHLTC "look[ed] at what was happening in other sectors", "draw comparisons to see what sort of increases were being proposed", and "had some discussions with regards to what would be considered possible and appropriate under the current fiscal constraints.[796]

Q. And so now there's an allegation made that midwives are experiencing gender discrimination. What did you do about that?

A. Yes. So that was -- it was the same argument that I had been -- that we had been having and the same discussion that we had been having for the last year,

---

795 Testimony of Melissa Farrell, Transcript, December 7, 2016, at pp. 38 – 39.

796 Testimony of Laura Pinkney, Transcript, December 2, 2016, at pp. 33 – 34.

but they had -- but the way in which they were talking about it was in a different way where they were talking about it as gender discrimination.

So I followed up with Health Human Resource. You know, it's a team effort. Followed up, you know, with people who I could really get some advice on. I sought legal advice associated with this. Followed up with the Labour Relations Secretariat. Spoke with the Health Human Resource area within the Ministry, just to understand if I'm -- if I was missing something in terms of the -- in terms of what I was hearing here.

Ultimately, the way that it was being described and discussed was in the context of the -- it was in the same context that it had been discussed in that last year, which was, again, about wage parity with the CHC physicians and NPs, and NPs are predominantly women, just as CHC physicians are predominantly women as well…

Q. And what was the -- what did the Ministry tell the AOM at that (April 29) meeting?

A. It was, essentially, it was very similar as the -- very similar messages to the messages, so we had the same conversation that we had been having, that we had been having before. So Susan (Fitzpatrick) reiterated the point that we couldn't provide any compensation increases. She talked to the Association about the fact that we couldn't -- that we had issues with the Courtyard report and that we wouldn't be implementing the Courtyard report. She talked more specifically about the compensation restraint policy, you know, discussed that I think in more detail with them as well.[797]

1105. Ms. Naylor identified that there was no policy that considers compensation required because of the *Human Rights Code* to be an exemption to the restraint provisions:

Q…is there any policy in the Ministry which considers compensation required because of the Human Rights Code to be an exemption to the restraint provisions, and was that applied here?

A. So, formal restraint provisions really relate primarily to the period from 2010 to 2012, although there are some policies and legislative parameters that still apply, for example, for executive compensation. But the government has been emerging from that period and making targeted investments and we've discussed some of those.

Q. But I'm asking about this period.

---

[797] Testimony of Melissa Farrell, Transcript, December 2, 2016, at p. 180.

A. So, certainly compensation that is awarded or ordered by a court or tribunal would be considered an exemption. Government would honour its obligations in those settings but, you know, government doesn't need that type of catalyst to make compensation adjustments. So, government will assess compensation cases on their merits and respond and, you know, and they do that on a regular basis and I expect, you know, the explicit goal of the process that's going on with my colleagues and the AOM now is to agree on a new funding mechanism with compensation increases.[798]

1106. The MOHLTC also has no policy in place in its budgeting policies to account for payments that might need to be made to address equity:

Q. And do you know whether any budgeting has ever been set aside for an adjustment for the midwives that would be over and above what would be considered normal within these processes… For an adjustment to them, if it's required, for ensuring that their compensation is free of sex discrimination, has the Ministry ever said, okay, we think this may be a problem? We're going to set aside the money so it's in a budget.

A. To my knowledge, I don't believe that there is a budget. There isn't a budget set aside for -- maybe I wasn't clear on how it's my understanding how this would work, but if there was a decision that was made to provide an increase… that was connected to, and the government was required or obligated to provide that increase, then we have to find that within the existing budget. So, it's not that it's necessarily been set aside. It's more likely that at the time of budgeting or within year budgeting we would be re-profiling or repositioning dollars to put toward this new requirement or obligation of the government."[799]

Q. So, if this Tribunal made an order that there were adjustments required to the pay…is it your understanding then that that order and those monies would not come under compensation restraints […]

A. It would not fall under compensation restraint.

Q. All right. And then as I understand what you're saying is the Ministry would just have to find the money?

A. Yes… whether or not there would be a specific allocation that would be set towards this or not I think would depend on what time of year it is and how we feel the situation is moving.[800]

---

798 Testimony of Nancy Naylor, Transcript, November 3, 2016, at pp. 182– 183.

799 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p. 64.

800 Testimony of Melissa Farrell, Transcript, December 7, 2016, at pp. 64 – 65.

1107. This is affirmed in Ms. Farrell's testimony when asked to be taken to a comment by MOHLTC Ontario Midwifery Program staff member Heather MacDermid:

Then at Tab 67 there is an e-mail from Ms. MacDermid who is setting out what could be a possible response to the letter, and she says: "A decision to consider midwifery compensation in the context of pay equity needs to be made at the highest levels of the government. Even if the government agrees that there is a wage parity issue, the Ontario government is not currently in a fiscal position to grant an immediate pay adjustment. [801]

1108. Former AOM President Katrina Kilroy testified to the challenge of having no process on which to rely and address the inequity:

As midwives, what process did we have? And, you know, I would go back to we tried very hard to establish that we had some rights to process at all. We -- this is the only process we have that will address the question of equity and the question of sex-based discrimination, is here at the Human Rights Tribunal. We tried every other tool at our disposal. I wouldn't call them processes, but all of our opportunities to have dialogue, to speak directly to government representatives, to present arguments to the Public Service people who were in charge of what happened to us, to present to a third party person who could give advice and recommendations, to engage in political -- try and bring some political pressure to bear. We tried all of those processes and they were ineffective in establishing any -- bringing any equity lens or any gender lens from the Ministry to the work that we do, and that's why we're here[802]*.*

1109. AOM President Elizabeth Brandeis summarized the effects of the MOHLTC having no processes to address inequity and claims of discrimination:

Q. And you also answered in relation to a question by Ms. Harris around the "Born Without a Contract" campaign which was dealt with in paragraph 91 of your affidavit, and you indicated you were looking for a forum to negotiate pay equity. And did you ever find that forum?

A. No. No. That's why we're here.[803]

K. MOHLTC dismissed pay inequity allegations without due consideration because midwives did not fit within the Pay Equity Act

1110. The MOHLTC, since the release of the Courtyard report, has dismissed pay equity issues raised by the midwives, claiming that they cannot be addressed because midwives are not employees and not covered by the PEA; this is

---

801 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p. 221.

802 Testimony of Katrina Kilroy, Transcript, October 7, 2016, at pp. 78 - 79.

803 Testimony of Elizabeth Brandeis, Transcript, October 11, 2016, at p. 9.

despite the fact that the AOM never claimed that midwives were covered under the PEA, but equity like that the MOHLTC afforded to other women compensated by the MOHLTC should be available to the midwives. As a result, the AOM began to change its terminology so that their concerns would not be so easily dismissed. Ms. Stadelbauer and Ms. Brandeis testified to this:

Q. So, in your letters and your affidavit you're using "pay equity", "wage parity", "fair compensation relative to other health care professionals", "equity", "equitable compensation", you're using all those terms interchangeably?

A. I think that's fair to say. I mean, in our minds, there was this inequity and the inequity stemmed from the fact that it was a female-dominated profession that didn't have access to processing that could address the inequities. And we knew that, as independent contractors, midwives didn't have access to pay equity legislation. So, it was challenging to know whether or not to use that language "pay equity", using air quotes here, because we found that when we used those words, the magic words "pay equity", the immediate response is midwives aren't eligible for pay equity because you're not part of -- you're not employees and not under that legislation. So, I think you do see changes in our language in part to reflect that we want to make sure that we're not shut down before we even start. And sometimes we found when we used the words "pay equity" we were shut down without being heard."[804]

Susan Fitzpatrick I know had stated that at a previous meeting because we don't fall under Pay Equity Act legislation because we're not employees, that we can't use the term "pay equity". So I think the semantics are -- can be a bit confusing when we're talking about pay equity and wage parity somewhat interchangeably, and that was really I think at the direction of hearing from government, "You don't have access to pay equity legislation, so don't call it that," and felt that wage parity was an option that captured the same spirit.

I do have to say that both speaking of pay equity and wage parity, really what we were asking for was some kind of relative positioning of midwifery within that broader context, and so a pay equity analysis I have come to learn means a particular rigorous process that was begun to an extent, we've talked about the Morton report as a rough pay equity analysis, but that relative positioning of saying this work is worth somewhere between here and here is what we were asking for.[805]

1111. The AOM first raised concerns about the potential for biases in compensation setting at the negotiations meetings in the winter of 2009. These concerns were repeatedly raised, but the MOHLTC took no action to address these concerns from a gender discrimination perspective. The only time there was some

---

804 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, at pp.199-200.

805 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at pp.115-116.

evidence of action on the MOHLTC's part was in April 2013. Ms. Farrell testified to the action she took at this time:

Q. And so in your exchange you're saying at the bottom of your e-mail: "They will ask us with the Pay Equity Act though." So you're still thinking that they are talking about the Pay Equity Act?

A. So, this is right after the conversation that I had had with the Association where they were talking where they had said this is about gender discrimination. We have received a letter where they were saying this is about gender discrimination. It's still referring -- it's still the context for us at this point in time was about the Courtyard report and putting -- that was the context that we had in terms of what they were talking about and what they were meaning. But then they also raised the Pay Equity Act with me in that meeting which we've already went through where they said, you know pay equity. That jurisdictional analysis doesn't make sense when we are talking about pay equity. …Kelly [Stadelbauer]… is the one who said it to me. So, this is why again part of the assessment and review we did between this time period, the letter comes in, again, I'm following up with the groups to get a legal position on this."[806]

"... So, that was the point in time where I went back and got -- sought legal advice. It felt like they were saying something different to me about the situation than the way that it had been described before. And it was the way in which it continued though to be described was in connection to the Courtyard report and what the Courtyard report said, and the argument appeared to be about gender discrimination in the context of CHC physicians and nurse practitioners. CHC physicians and nurse practitioners are predominantly women so it felt like -- I'm just saying that we -

Q. So, you end up keep dismissing it because you think the comparators are women?

A. I think what -- what the way in which the argument was being presented it was in the context of an interest in a 20 percent equity adjustment that had been included within the Courtyard report as a recommendation by Courtyard, and it was about something -- it was about CHC physicians and nurse practitioners.

Q. And were you aware that we've had evidence that they raised this problem of the jurisdictional analysis in the Courtyard process and that it was inappropriate and under the Pay Equity Act, and that would have been in August of 2010?

A. I'm not aware that it was raised in the context of the Pay Equity Act or not. I certainly know that they felt very strongly that their compensation should be in

---

806 Testimony of Melissa Farrell, Transcript, December 8, 2016, pp. 28 - 29.

between CHC physicians and nurse practitioners and that they weren't in favour of the jurisdictional analysis.[807]

1112. Ms. Farrell testified that she had heard that the AOM started to use wage parity because the Ministry didn't think pay equity applied to them.[808] The MOHLTC also made deliberate efforts to avoid using the term “pay equity”. Evidence was given by Ms. Farrell and Ms. Pinkney about this use of language by the MOHLTC to avoid their Code obligations:

This says pay inequity … this is a confidential draft version, the terminology and, again, it's connecting this pay equity or the pay inequity to the Courtyard report in particular, and the 20 percent compensation increase that had been recommended within that third party compensation review. So, it's still in the context of the Courtyard report. For a long period of time we were talking about it in terms of wage parity, about the CHC physicians, nurse practitioners, that's the way it was described.[809]

Q. "Can relativity be addressed?" And Susan Fitzpatrick's answer was, "No." But the: "Overall, yes we accept that there is relativity issue. "Still have questions on the report." And then you get questions in that meeting about what evidence-based outcomes would be because you put forward that there would be this evidence-based outcome increase. And then at the bottom, Ms. Stadelbauer asks, "Pay equity gap?" And then Ms. Fitzpatrick says, "We asked [about] it. Doesn't fit into pay equity." So that's the response, right?

A. Yes. I recall Susan giving that direction at the meeting.

Q. All right. And then Ms. Kilroy says, "Why not pay equity?" And Ms. Fitzpatrick says: "Clear parameters in the legislation - exception narrowly limited, just to the legislation." And then there's: "Recognize AOM will see certain agreements in the media [that it's] a different process. "Different routes - collective frameworks..." So this is that money that other professionals are getting, they're getting because they have different collective agreement frameworks or processes?

Or provisions, yes.[810]

1113. The MOHLTC had identified internally that there were “risks associated with linking a compensation increase for midwives to pay equity”, and therefore,

---

807 Testimony of Melissa Farrell, Transcript, December 7, 2016,pp. 42 – 43.

808 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p. 149.

809 Testimony of Melissa Farrell, Transcript, December 7, 2016, pp. 148 – 149.

810 Testimony of Laura Pinkney, Transcript, December 2, 2016, at pp.99 - 100.

steered towards using the terminology of "relativity" rather than equity[811]. Ms. Pinkney described this risk in her testimony:

As has been outlined previously that this didn't fall within pay equity legislation, so there was lots of discussion where, initially, comments had been made about equity and what was being meant by equity initially was thought to be equity with other providers, but then that became a question of pay equity under pay equity legislation, and so you'll still see references in some of the e-mails to things coming forward with regards to pay equity…And then taking steps to address what pay equity would actually mean under the legislation, and so you start to see some alternate wording to look at things like "relativity" being used as opposed to making references specifically to pay equity."[812]

L. MOHLTC Refuses to Separate Pay Equity Issue from Contract Negotiations

1114. The AOM attempted to separate out the equity issues from bargaining, recognizing that equity should not be negotiated. The MOHLTC refused this suggestion by the AOM. Ms. Stadelbauer and Ms. Brandeis both testified to this:

But we also had discussions beyond the OMP staff. So, at this point we were trying to connect with staff in the Minister's office, in the Premier's office, just trying to find where there was a possible solution to this challenge, still very much wanting to work with government to resolve this…we were looking for creative solutions. We were trying to understand why the government wasn't moving on the Courtyard report. We didn't understand what their objections were about. We wondered if part of it was a political issue. We were trying to find ways to help them help us through this.

And one of the conversations was about you don't negotiate equity, and a penny dropped for us I think at that point that, yeah, they should really be separate processes. To mix pay equity considerations into a collective bargaining consideration isn't right and they needed to be separated out. And so we thought that that might be a way forward too for the government that they were able to, if they could separate those processes out, put them at two separate tables, it might help clarify the real issues which is, first and foremost, how do you provide equity in the compensation for midwifery; and then, secondly, what's the collective bargaining about in terms of the contract…?

We had a really pivotal meeting on December 4th with Minister Matthews, and at that meeting we asked for a binding pay equity review that was distinct from the contract negotiations, and separating that out from the process of negotiations…

---

811 "Midwifery compensation options - July 12 2011 (2)", Government Documents - Laura Pinkney, Volume IV (Exhibit 160, Tab 277).

812 Testimony of Laura Pinkney, Transcript, December 2, 2016, at p. 109.

The Minister said no to something that was binding but we heard her say that she and the Ministry were willing to provide a separate process for the wage parity issue is what they called it, but pay equity is what we were calling it, and a separate table for negotiations for the contract issues…

She tasked Melissa Farrell who was the director at that time for the Primary Care Health Branch, to take that on. And then two days later we were in that meeting with Ms. Farrell and suddenly the message had changed which was really frustrating for us because there had been three AOM representatives in that room that had all heard the same thing, Ms. Farrell was in that room, and then we got to the meeting two days later and heard something completely different and, in fact, those discussions wouldn't be separated out and that it wasn't -- and it was a bit wishy-washy as to whether it was actually going to be a pay equity review.[813]

Q. And you state there that: "We requested that the pay equity issue be dealt with by the creation of an objective and specific process to facilitate pay equity/wage parity. In doing so, we noted that 'the midwifery profession, made up of female front line workers serving women clients, does not have access to labour legislation to mandate fairness, and therefore we rely on your government to negotiate fairly and in good faith with us, including negotiating in a timely manner'." Why did you want a separate process to address the pay equity issue?

A. We believed strongly that the issue of fair pay should not be part of our contract negotiations, discussions, that we didn't feel we should be negotiating fairness, that that should be a separate process, an evaluation that isn't about the conditions and structure of how midwives work. Negotiations felt more appropriate for things like negotiating cost of living increases, benefits improvements, those kinds of things, whereas an equity adjustment felt like it ought to have a separate process and a dedicated process so it wasn't seen that we're negotiating our rights.

Q. Okay. And when you requested that of the Ministry, what did they say? Did they ever provide that process?

A. That process has never been provided.…There was no interest at all at that table to address these issues. We were told that was the forum that we had to discuss matters, and just kind of backing up to what I was speaking of earlier about being told very clearly that we were not the bargaining agent for midwives, we were told this is not a place for bargaining or negotiating. It's a place for discussions. So no, there was no platform within that, within that committee to discuss pay equity.[814]

---

813 Testimony of Kelly Stadelbauer, Transcript, October 11, 2016, at pp. 50 - 54.

814 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at pp.113-115.

M. MOHLTC Response does not Reflect Understanding of Human Rights issues and Systemic Gender Discrimination in Compensation

1115. The response to the AOM, the response to the midwives' application to the HRTO, and the responses during these hearings demonstrate a lack of understanding evaluation of equitable compensation, gender discrimination issues (particularly in the health care context) and the Human Rights Code:

1116. For example, Ms. Scarth testified to her lack of understanding how to evaluate equitable compensation, and that knowledge of systemic gender discrimination and Code issues were not to be found within the Primary Care Branch:

I would say my understanding of a pay equity analysis is an analysis undertaken of different job classes or professional groups on the basis of a set of criteria of skills, effort, responsibility, workload, and it's a fairly structured process. It's not an area of expertise for me though"[815]

Do you understand that part of the understanding about having a male comparator is that it's to a male pattern of wages and that's why it's a technique for identifying whether there is systemic gender discrimination?

A. So, as I said, this is not a particular area of expertise of mine. My area of expertise is in program management and policy work in the context of delivering health services.

Q. Right. So, I guess I tried to ask this question with a number of people is that who had some gender expertise in the Ministry that could be brought to bear on this if you're saying now you didn't really have it because you're a program manager? We've heard from other witnesses that a gender lens was not used in relation to this program and this compensation. So, who was supposed to be applying this gender lens?

A. Well, so you have been asking me about terms and processes that are specific to pay equity, and, you know, there are within government areas of -- areas of government that do specialize in that and we seek advice from them when we need to. But I wasn't in the program and in this role of managing the midwifery program…I would say there are areas within the Ministry of Health that focus more on health human resources and the patterns of employment within the health sector. We have a division whose name keeps changing but it's something like Health System Regulatory Affairs and Health Human Resources. We have an area of the Ministry that deals more specifically with labour issues and labour negotiations. So, there are other areas in the Ministry that have more expertise that's specific to these kinds of processes than I would have.

---

[815] Testimony of Fredrika Scarth, Transcript, December 8, 2016, at p. 139.

Q. Right. Well, if you don't have it, we've certainly not heard of it from anyone else."[816]

1117. The testimony by Ms. Pinkney was surprising with regards to her lack of knowledge of applying to a gender lens to the development of policy, particularly in the context of the high occupation-segregation of the health care sector, with direct responsibility for the midwifery portfolio.

1118. The Negotiations Branch flagged the issue of a potential risk for the MOHLTC under the Code, but demonstrated a lack of understanding of the MOHLTC's obligations when a) it failed to investigate to find out whether there was gender discrimination in place in the compensation setting of midwives and b) failed to show an understanding of how systemic gender discrimination works by dismissing the risk with this comment: "While not mentioned by AOM, there is an outside risk they could bring an equity issue forward under the Human Rights Code, but [nurse practitioners] are a female dominated group as well, and the argument to compare Midwives scope of practice to Obstetricians is not clear."[817]

N. MOHLTC Believes Up to Midwives to Secure Human Rights Code Obligations

1119. Ms. Pinkney testified that midwives had not raised the Human Rights Code when making their allegations, and therefore there was no investigation under the Code:

Q. And you're aware that the compensation restraint policy also referred to the Human Rights Code, not just the Pay Equity Act?...So this section is 12(3):

Nothing in this Act shall be interpreted or applied so as to reduce any right or entitlement under the Human Rights Code or the Pay Equity Act"….So what kind of analysis did the government do with respect to whether or not the midwives had any entitlement under the Human Rights Code to a pay equity adjustment?

A. During that period of time, there wasn't an issue raised with regards to the Human Rights Code. The specific request that came up to my recollection was pay equity, so we had looked at the question of a pay equity exemption, whether that applied."[818]

1120. Ms. Farrell testified that the midwives were told that they were welcome to commission another report to replace the Courtyard report;[819] however, there was no assurance that the MOHLTC would take it into consideration in the

---

816 Testimony of Fredrika Scarth, Transcript, December 8, 2016, at pp. 143 – 144.

817 Testimony of Laura Pinkney, Transcript, November 4, 2016, at pp. 58 – 59.

818 Testimony of Laura Pinkney, Transcript, December 2, 2016, at pp. 36 – 37.

819 Testimony of Melissa Farrell, Transcript, December 7, 2016, at p. 217.

setting of midwifery compensation. This demonstrates the attempt to shift the obligation to the midwives to ensure their human right to compensation free of gender discrimination.

1121. Ms. Naylor testified to the fact that "a fair amount of analysis" was prompted by the allegation and that this can be verified by her schedule.[820] But since Ms. Naylor only joined the MOHLTC in 2014, after the filing of the midwives' application to the HRTO, one can surmise that Ms. Naylor is not actually referring to any investigation or analysis of the allegation, but of the application itself. These actions do not alleviate the MOHLTC from their obligations under the Code.

1122. Ministry's counsel in these proceedings have also implied that the onus was on the midwives to identify the Code violations:

Q. At either of these meetings, did the AOM tell you that the Ministry had a Human Rights Code obligation to do a binding compensation review?

A. No.

Q. Did they tell you that the Ministry had a Human Rights Code obligation to do an assessment of the skill, effort, responsibility and working conditions of midwives?

A. No.[821]

Q. But the AOM at this point is not putting forward any other comparators; is that correct?

A. That's correct. We believed that that was the Ministry's work to do."[822]

PART 32: MOHLTC CHC PHYSICIAN COMPENSATION SETTING

1. Community Health Centres

1123. 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

820 Testimony of Nancy Naylor, Transcript, November 3, 2016, at p. 180.

821 Testimony of Nancy Naylor, Transcript, November 3, 2016, at p. 176.

822 Testimony of Elizabeth Brandeis, Transcript, October 7, 2016, at p.169.

senior primary care nurses in the CHCs came to be known as nurse practitioners for the extended responsibilities of their practice.

1124. 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.

1125. AOM Witness Theresa Agnew, a nurse practitioner and head of the Nurse Practitioners Association of Ontario and previously a long time CHC employee, testified concerning this extensive model of collaboration. Many of the care tasks which CHC physician witnesses referred to in their affidavits are, in fact, also provided by other professionals, including nurse practitioners.

1126. 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.

1127. 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.

1128. 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.[823] 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.[824] Most of these locations are situated in the same local areas as midwifery catchment areas and many of the underserviced areas for CHCs which merit the higher physician compensation grid are also underserviced areas where midwives practice. Between 2007 and 2011 CHC funding was devolved to the Local Health Integration Networks (LHINs).

---

823 See Dr. Chandrakant P. Shah and Dr. Brent w. Moloughney, "A Strategic Review of the Community Health Centre Program", Affidavit of Jane Kilthei (Exhibit 1, Tab 17) for a detailed review of this Program and the work of CHC physicians and nurse practitioners.

824 "Community Health Centres in Ontario- Accreditation Canada" Government Documents – Thornley (Exhibit 179, Tab 57).

2. CHC Physician Compensation

1129. 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 Nurse II."[825] These salary ranges were detailed in the Ministry's 1991 CHC Compensation Review. These salary ranges are set out in the Morton report.

1130. 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.

1131. 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.[826]

1132. The data originally available to the AOM on which Mackenzie made initial calculations regarding CHC physician compensation has only accounted for Base Salary, benefits and on-call fees.

1133. However, through disclosure, it became apparent that from 2004 to 2010 CHC physicians were also eligible for further incentive payments such as 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. [827] During this period in the CHC model, the CCM fee per

---

825 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/)

826 "Community Health Centres in Ontario- Accreditation Canada" Government Documents – Thornley (Exhibit 179, Tab 57).

827 "Options for Aligning CHC Compensation - 17 Aug 2009 - Working Paper" Government Documents – Pinkney (Exhibit 160, Tab 112) at p. 2.

physician depended on the average number of enrolled patients for all physicians (all patients enrolled by CHC physicians were pooled).[828] 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.

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

1134. 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.

1135. 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).[829] 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:

(a) FFS Flow through Physician Compensation Adjustments
(b) Comprehensive Care Capitation and Primary Care Physician Incentives and Bonuses
(c) Continuing Medical Education payments
(d) Per patient rostering fee[830]

1136. 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. These were not regarded as part of the physician's total compensation.

Coping with Uncertain Data: Interim Payments

1137. 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:[831]

---

828 "Options for Aligning CHC Compensation - 17 Aug 2009 - Working Paper" Government Documents – Pinkney (Exhibit 160, Tab 112) at p. 2.

829 "Update on CHC Physician Compensation for PHC Executive, dated March 2, 2010" Affidavit of Laura Pinkney (Exhibit 158, Tab 206).

830 "Overview: Harmonization of Community Health Centres, dated May 15, 2009" Affidavit of Susan Davey (Exhibit 135, Tab 238).

831 "CHC Salary Scales Sent from OMP to Courtyard" Affidavit of Katrina Kilroy (Exhibit 91, Tab 55).

year	Not designated underserviced	Northern/designated underserviced
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

1138. However, these figures to do not account for the additional incentive payments introduced as a result of OMA bargaining.

1139. The OMP did not disclose the further incentive payments to Courtyard and AOM unaware of them.

1140. 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."[832] In May 2007 the Primary and Community Care Committee (PCCC) approved interim and retroactive incentive payments to be made to CHC physicians" as follows:[833]

- 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) [834]

1141. 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."[835]

---

832 "Implementing the Primary Care Incentives in the 2004-08 Agreement between MOHLTC and OMA (est 2005)" Affidavit of Tara Kiran (Exhibit 173, Tab 88).

833 "Internal MOH Briefing Note by David Thornley re: CHC Physician Compensation Payments (email attaching AOM0013473)" Government Documents – Thornley (Affidavit 179, Tab 25) at p. 4.

834 "MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups - Summary (2008-01-01)" (Exhibit 132).

835 "Letter from G. Smitherman to G. Stein (President, South-East Ottawa Community Services) re: Harmonized Compensation for CHC Physicians (Nov 2005)" Affidavit of Theresa Agnew (Exhibit 129, Tab 49).

1142. Based on the documentation which has been produced to the Applicant to date, it is difficult to calculate precisely the increase in compensation to CHC physicians during this period. It is clear that payments for physician incentives and bonuses were made in December 2005,[836] June 2006,[837] April 2007 and March 2008.[838] 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. [839] 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 claims[840] 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.[841]

1143. 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.

Controversy Caused by Rostering

1144. The requirement that CHC's roster patients to the physicians caused a degree of controversy. This was because many patients that physicians billed for had never even seen a physician, and were cared for by a Nurse Practitioner. Also stoking controversy was the fact that rostering promoted billing for services that were considered to already be part of quality primary care. Despite these concerns, the MOHLTC continued the direction to roster CHC patients. An internal MOHLTC memo from 2009 notes that "the physicians are receiving the incentive and bonus payments for the work of NPs".[842]

---

836 "Overview Harmonization of Community Health Centres (2009-05-15)" Affidavit of David Thornley (Exhibit 132, Tab 27).

837 "Overview Harmonization of Community Health Centres (2009-05-15)" Affidavit of David Thornley (Exhibit 132, Tab 27).

838 "MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups - Summary (2008-01-01)" (Exhibit 132).

839 "MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups - Summary (2008-01-01)" (Exhibit 132).

840 "MOH Briefing Note: (Incentive/Bonus) Interim Payments to CHC Physician Groups - Summary (2008-01-01)" (Exhibit 132).

841 "Memo from J. Barber (Manager, CHC Program) to D. Hole (Executive Director, South-East Ottawa Community Services) re: Salary Surpluses (Jan 2007)" Affidavit of Sue Davey (Exhibit 142, Tab 108).

842 "Overview Harmonization of Community Health Centres (2009-05-15)" Affidavit of David Thornley (Exhibit 132, Tab 27).

The 2008 Physician Services Agreement

1145. 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.

1146. 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"[843] As of 2008 the base salary of CHC physicians in CHCs Not designated underserviced was $124, 460 to 149, 945 and in underserviced CHCs was $157, 772 to 190, 074.[844] In 2009 the base salary was 140, 434.55 to $157, 142.02 for not underserviced CHCs and $165, 345.56 to $199, 197.52 for underserviced CHCs. [845]

Collapse of the blended salary model

1147. The goal of the MOHLTC was for the incentive payments to be based on actual patient enrolment after April 1, 2009.[846] The goal of the MOHLTC was for incentive payments to be based on actual patient enrolment after April 1, 2009.[847] 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 substantial overpayments to physicians in the previous years.

Introduction of a full salary model

1148. In January 2010, the Physician LHIN Tripartate Committee (PLTC) decided that CHC physicians would move to a fully salaried compensation model effective April 1, 2010.[848] The new salary ranges were based on CHC physician FTE base

---

843 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

844 "Options for Aligning CHC Compensation - 17 Aug 2009 - Working Paper" Government Documents – Pinkney (Exhibit 160, Tab 112) at p. 2

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

846 "Internal MOH Briefing Note by David Thornley re: CHC Physician Compensation Payments (email attaching AOM0013473)" Government Documents – Thornley (Affidavit 179, Tab 25) at p. 4.

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

848 "Update on CHC Physician Compensation for PHC Executive, dated March 2, 2010" Affidavit of Laura Pinkney (Exhibit 158, Tab 206).

salaries and an estimate of the CHC value physician FTE annual incentives and bonuses.[849] In other words, the value of the incentives were rolled into the base salary of CHC physicians.

1149. 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.

1150. 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)[850]		
Payment Element	Communities not designated underserviced	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
+ 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

849 "Update on CHC Physician Compensation for PHC Executive, dated March 2, 2010" Affidavit of Laura Pinkney (Exhibit 158, Tab 206); "Letter from MOH to Champlain LHIN re physician compensation increase (May 2010)", Government Documents – Laura Pinkney (Exhibit 160, Tab 138).

850 "Update on CHC Physician Compensation for PHC Executive, dated March 2, 2010" Affidavit of Laura Pinkney (Exhibit 158, Tab 206).

Conclusion

1151. The AOM submits that the evidence set out above provides the foundational support to conclude that the MOHLTC, as alleged in paragraph 62 of Schedule A to its November, 2013 application:

(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,"39 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.

1152. Accordingly, the AOM submits that it has overwhelmingly proven that midwives have suffered adverse gender impacts.